8.500 HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED (HCB-DD) WAIVER

8.500.1 DEFINITION

Home and Community Based Services for the Developmentally Disabled (HCB-DD) waiver services shall be provided in a home or community based setting to persons with developmental disabilities who meet the level of care criteria for long term care programs for the developmentally disabled and who are eligible under the Medicaid waiver for programs for the developmentally disabled as a cost effective alternative to institutional placement.

8.500.2 PROGRAM ADMINISTRATION

Home and Community Based Services for the Developmentally Disabled (HCB-DD) shall be provided in accordance with the federally approved waiver document and these rules and the rules and regulations of the Colorado Department of Human Services entitled RULES AND REGULATIONS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES and promulgated in accordance with the provisions of section 26-4-624, C.R.S. In the event a direct conflict arises between the rules and regulations of the Department of Health Care Policy and Financing and the Department of Human Services, the provisions of section 26-4-624(5), C.R.S., shall apply and the regulations of the Department of Health Care Policy and Financing shall control.

The Home and Community Based Services for the Developmentally Disabled (HCB-DD) waiver program is administered by the Department of Human Services, Developmental Disabilities Services, under the oversight of the Department of Health Care Policy and Financing.

8.500.3 PROGRAM PROVISIONS

The following provisions shall apply in regards to the Home and Community Based Services for the Developmentally Disabled (HCB-DD) waiver.

A. Home and Community Based Services for the Developmentally Disabled (HCB-DD) shall be provided as an alternative to institutional placement for individuals with developmental disabilities and include personal care, habilitation residential programs, non-medical transportation, assistive technology, home modification, and habilitation day programs. Individuals eligible for these services shall be eligible for all other Medicaid services for which they qualify.

B. HCB-DD waiver services shall be waived from the requirements in Section 1902(a)(10)(B) of the Social Security Act concerning comparability of services. The availability of some services may not be consistent throughout the State of Colorado.

C. HCB-DD waiver services shall be structured to make various services available to individuals based on the level of care certification.

D. Case management agencies shall provide case management services including assessing the individual's needs to determine if HCB-DD waiver services are appropriate; completing the individual's Individualized Plan(IP); and submitting the Individualized Plan to the Department of Human Services, Developmental Disabilities Services, for review and approval for HCB-DD waiver services. These Individualized Plans shall be subject to review and approval of HCB-DD waiver services by the Department of Health Care Policy and Financing.

   a. Every IP shall include a process by which the client receiving services may receive necessary care, for medical purposes, if the client’s service provider is unavailable due to an emergency situation or to unforeseen circumstances. The client who is receiving the

services and the client's family or guardian shall be duly informed of these alternative care provisions at the time the IP is initiated.

b. The case management agency shall not be required to provide services set forth in the IP for alternative care provisions that it is not otherwise required to provide to the client, but shall be required to include in the plan of care the contingency for such services.

E. The client receiving services is responsible for cooperating in the determination of financial eligibility, including prompt reporting of changes in income or resources; cooperating with the case manager and service providers as agreed to in the Individualized Plan; choosing between HCBDD waiver services and institutional care; and where assessed, remitting patient payments by the due date.

8.500.4 ELIGIBLE PERSONS

.41 Home and Community Based Services for the Developmentally Disabled (HCB-DD), under the HCB-DD waiver #007.91, shall be offered to individuals with developmental disabilities:

A. who meet the medical assistance eligibility criteria as specified at §8.110.8 in this manual; and,

B. who have been determined to meet the level of care criteria for long term care programs for the developmentally disabled; and,

C. who have been assessed as potentially appropriately served through the HCB-DD program through application of the Institutional Profile; and,

D. for whom a Plan of Care (POC) has been developed which conforms to the purchase of services limitations as provided herein; and,

E. provided the individual can be served within the federally approved capacity limits of the waiver; and,

F. who receive at least one waiver service each month.

.42 Persons determined eligible to receive services and supports under the HCB-DD waiver which are not immediately available within the federally approved capacity limits in the waiver, shall be eligible for placement on a waiting list for services and supports.

A. Waiting lists for persons eligible for the HCB-DD waiver program shall be maintained by the Community Centered Boards, uniformly administered throughout the state and in accordance with these and DHS/DDD rules and guidelines.

B. Persons determined eligible shall be placed on the waiting list for services and supports in the service area of residency.

C. Persons who indicate a serious intent to move to another service area should services and supports become available shall be placed on the waiting list in that service area. Placement on a waiting list in a service area other than the area of residency shall be in accordance with criteria established in DHS/DDD guidelines for placement on waiting lists in a service area other than area of residency.

D. The date used to establish a person's placement on a waiting list shall be:

1. The date on which eligibility for developmental disabilities services in Colorado was

originally determined; or,

2. The fourteenth (14) birth date if a child is determined eligible prior to the age of fourteen and is waiting for adult services.

E. As openings become available in the HCB-DD waiver program in a designated service area, persons shall be considered for services and supports in order of placement on the local Community Centered Board's waiting list and with regard to an appropriate match to services and supports. Exceptions to this requirement shall be limited to:

1. Emergency situations where the health, safety and welfare of the person or others is greatly endangered and the emergency can not be resolved in another way. Emergencies are defined as follows:

a. Homeless : the person does not have a place to live or is in imminent danger of losing his/her place of abode.

b. Abusive or Neglectful Situation : the person is experiencing ongoing physical, sexual or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.

c. Danger to Others : the person's behavior and/or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision can not be provided by the current caretaker to ensure safety of persons in the community.

d. Danger to Self : a person's medical, psychiatric and/or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.

2. The Legislature has appropriated funds specific to individuals and/or to a specific class of persons.

F. If an eligible individual is placed on a waiting list for HCB-DD waiver services, a written notice, including information regarding client appeals shall be sent to the individual and/or their legal guardian in accordance with the provisions of 10 CCR 2505-10 Section 8.057 et seq.

.43 Individuals with developmental disabilities who are residents of Nursing Facilities (NF's), Intermediate Care Facilities for the Mentally Retarded (ICF/MR's), or hospitals shall not be eligible for Home and Community Based Services for the Developmental Disabled (HCB-DD).

8.500.5 PROVIDERS

.51 Home and Community Based services for the Developmentally Disabled (HCB-DD) programs shall be provided by agencies that meet the following criteria:

Have received and/or maintained program approval from the Department of Human Services, Developmental Disabilities Services for the provision of HCB- DD waiver services; and Have a Medicaid Provider Agreement; and

A. have agreed to comply with all the provisions of Title 27, Article 10.5, C.R.S., and all rules and regulations promulgated thereunder; and

B. have, if applicable, the current required licenses from the Colorado Department of Public

Health and Environment.

8.500.52 Home and Community Based services for the Developmentally Disabled (HCB-DD) waiver providers shall cooperate in the following:

A. all state authorized on-site program reviews, whether for the purpose of program approval, on-going program monitoring, or state initiated financial and program audits; and

B. all state efforts to collect and maintain information on the HCB-DD waiver programs, whether required for federal or state program review and evaluation efforts, including information collection; and

C. any federal program reviews and financial audits of the HCB-DD waiver programs; and

D. providing access, by the County Departments of Social/Human Services, to records of persons receiving services held by case management agencies as required to determine and redetermine Medicaid eligibility; and

E. all efforts by the case management agency to review the provider's programs, whether generally or specifically for particular persons receiving services; and

F. all long term care determinations and continued stay reviews conducted by the Department of Human Services, Developmental Disabilities Services

G. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.500.6 INDIVIDUAL RIGHTS

The rights of a person receiving Home and Community Based Services are established in Title 27, Article 10.5, Sections 112 through 131, C.R.S., as amended. The rules and regulations regarding these rights are promulgated in Colorado Department of Health Care Policy and Financing, Section 8.484.20 of these rules, and the Department of Human Services, Division for Developmental Disabilities, Rules and Regulations, Chapter 6.

8.500.7 QUALITY ASSURANCE

The monitoring of Home and Community Based Services for the Developmentally Disabled (HCB-DD) waiver services and the health and well being of service recipients shall be the responsibility of the Department of Human Services, Developmental Disabilities Services, under the oversight of the Department of Health Care Policy and Financing.

The Department of Human Services, Developmental Disabilities Services, shall conduct on-site surveys of each agency providing HCB-DD waiver services. The survey will include a review of applicable rules and standards developed for programs serving individuals with developmental disabilities.

The Department of Human Services, Developmental Disabilities Services, shall ensure that the case management agency/community centered board fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with the assurances required of these programs.

The Department of Human Services, Developmental Disabilities Service;, shall maintain for three years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCB-DD waiver programs or the delivery of services under these programs. The

Department of Health Care Policy and Financing shall have access to these records at any reasonable time.

Developmental Disabilities Services shall recommend to the Department of Health Care Policy and Financing the denial and/or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to Developmental Disabilities Services within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

After having received the denial and/or termination recommendation and reviewing the supporting documentation, the Department of Health Care Policy and Financing shall take the appropriate action.

8.500.8 PATIENT PAYMENT - POST ELIGIBILITY TREATMENT OF INCOME

Individuals who are determined to be Medicaid eligible through the application of the 300% income standard at §8.110.8, are required to pay a portion of their income towards the cost of their HCB-DD services.

.82 This PETI (Post Eligibility Treatment of Income) payment :

A. shall be calculated by the case management agency during the individual's initial assessment for HCB-DD services;

B. shall not exceed the cost of HCB-DD services for the month for which payment is being made;

C. shall be recomputed monthly;

D. shall be collected and receipted by the case management agency as instructed by the State.

.83 In calculating PETI payment, the case management agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining Medicaid eligibility):

A. A maintenance allowance equal to the AND/SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of $245 per month; and

B. For an individual with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and

C. For an individual with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate AFDC grant level; and

D. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

1. health insurance premiums (other than Medicare), deductibles. or coinsurance charges (including Medicaid copayments); and

2. necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan.

.84 Case management agencies are responsible for informing individuals of their PETI obligation on a form prescribed by the Developmental Disabilities Services, Department of Human Services.

.85 PETI payments are due during the month following the month for which they are assessed.

.86 Case management agencies must submit all PETI assessments to the state on the form specified by the division, within 35 calendar days of the end of the month for which they were assessed.

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

8.500.90 DEFINITION

Supported Living Services (SLS) are services and supports which are available to assist persons with developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an SLS setting. Supported Living Services are subject to the availability of appropriate services and supports within existing resources.

8.500.91 PROGRAM ADMINISTRATION

The Supported Living Services program for persons with developmental disabilities is administered by the Department of Human Services, Developmental Disabilities Services under the oversight of the Department of Health Care Policy and Financing.

Supported Living Services for persons with developmental disabilities shall be provided in accordance with the federally approved waiver document and these rules and regulations, and the rules and regulations of the Colorado Department of Human Services, Developmental Disabilities Services (DDS), 2 CCR 503-1. In the event a direct conflict arises between the rules and regulations of the Department of Health Care Policy and Financing and the Department of Human Services, the rules and regulations of the Department of Health Care Policy and Financing shall control.

Supported Living Services shall not constitute an entitlement to services, from either the Department of Health Care Policy and Financing or the Department of Human Services. Supported Living Services shall be subject to annual appropriations by the Colorado General Assembly. The Department of Human Services, Developmental Disabilities Services shall limit the utilization of the Supported Living Services waiver based on the federally approved capacity and cost effectiveness of the waiver and the total appropriations, and shall limit the enrollment when utilization of the Supported Living Services waiver program is projected to exceed the spending authority.

Designated Community Centered Boards shall be responsible for performing all functions related to the provision of Supported Living Services, pursuant to 27-10.5-105, C.R.S., et seq. (1995 Supp.).

8.500.92 PROGRAM PROVISIONS

The State of Colorado requested and was granted authority to provide the following services under the Supported Living Services waiver.

A. Supported Living Services are provided as an alternative to institutional placement for individuals with developmental disabilities and include personal assistant services, habilitation services, environmental engineering, professional services, and dental services.

B. The Supported Living Services program is waived from the requirements of Section 1902(a)(10)(B) (comparability of services) and Section 1902(a)(l) (statewideness) of the Social Security Act Therefore, the availability and comparability of services may not be consistent throughout the State of Colorado.

C. Individuals eligible for services under the SLS program are eligible for all other Medicaid services for which they qualify and must first access all benefits available under the

regular Medicaid State Plan prior to accessing funding for those same services under the SLS program.

D. Case management agencies shall provide case management services under administrative activity including: assessment of the individual's needs to determine if SLS waiver services are appropriate; completion of the Individualized Plan (IP); and submission of the Individualized Plan to the Department of Human Services, Developmental Disabilities Services, for review and approval for SLS waiver services. These Individualized Plans are also subject to review by the Department of Health Care Policy and Financing.

E. The provision of Supported Living Services may be subcontracted by the SLS agency to other qualified agencies, professionals, individuals, or family members living in the same household as the person with a developmental disability, or vendors in order to provide additional opportunities for individual choice and the use of general services,

F. The individual receiving services and/or his/her family or guardian are responsible for cooperating in the determination of financial eligibility, including prompt reporting of changes in income or resources; cooperating with the case management agency and service providers as agreed to in the Individualized Plan; and choosing between SLS waiver services and institutional care.

8.500.93 ELIGIBLE INDIVIDUALS

Supported Living Services may be offered to an individual who meets the following criteria:

A. Has been determined to have a developmental disability as defined in Section 27-10.5-102, C.R.S., (1995 Supp.), by a designated Community Centered Board; and

B. Is an adult, eighteen (18) years of age or older; and

C. Has been certified by the Department of Human Services/Developmental Disabilities Services through the ULTC-100 and LTC-102 assessment forms that he/she meets the established minimum criteria used in the designated screening instrument for the Level of Care for placement into an Intermediate Care Facility for the Mentally Retarded (ICF/MR); and

D. For whom an Individualized Plan (IP) has been developed which conforms to the purchase of service limitations as provided herein; and

E. Meets the medical assistance eligibility criteria as specified in the section on PERSONS RECEIVING HOME AND COMMUNITY-BASED SERVICES at §8.110.8; and

F. Does not require twenty-four (24) hour supervision on an ongoing basis which is paid for with SLS funding; and

G. Resides in an eligible SLS setting. SLS settings are the individual's "own home" which is defined as the following:

1. A living arrangement (e.g., home, apartment, or condominium) which the individual owns or rents or leases in his/her own name; or

2. The home where the individual lives with his/her family or legal guardian; and

3. No more than three (3) persons receiving Supported Living Services may reside in one household, unless they are all members of the same family; and

H. The individual receiving Supported Living Services is not simultaneously enrolled in the Home and Community-Based Services for the Developmentally Disabled (HCB-DD) program, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program or any other waiver program; and

I. The individual is not residing in a hospital, nursing facility or ICF/MR; and

J. Provided the individual can be served within the federally approved capacity and cost effectiveness limits of the waiver; and,

K. The individual receives at least one waiver service each month.

8.500.94 WAITING LIST PROTOCOL

Persons determined eligible to receive services under the SLS federally approved capacity and cost effectiveness limits of the waiver, shall be eligible for placement on a waiting list for services.

A. Waiting lists for persons eligible for the SLS waiver program shall be administered by the Community Centered Boards, uniformly administered throughout the State and in accordance with these rules and the Department of Human Services, Developmental Disabilities Services (DHS/DDS) guidelines.

B. Persons determined eligible shall be placed on the waiting list for services in the service area of residency.

C. Persons who indicate a serious intent to move to another service area should services become available shall be placed on the waiting list in that service area Placement on a waiting list in a service area other than the area of residency shall be in accordance with criteria established in the DHS/DDS guidelines for placement on a waiting list in a service area other than the area of residency.

D. The date used to establish a person's placement on a waiting list shall be:

1. the date on which eligibility for developmental disabilities services in Colorado was originally determined; or

2. the fourteenth (14th) birthdate if a child is determined eligible prior to the age of fourteen and is waiting for adult services.

E. As openings become available in the SLS waiver program in a designated service area, persons shall be considered for services in order of placement on the local Community Centered Board's waiting list and with regard to an appropriate match to services and supports. Exceptions to this requirement shall be limited to:

1. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered and the emergency cannot be resolved in another way. Emergencies are defined as follows:

a. Homeless : the person does not have a place to live or is in imminent danger of losing his/her place of abode.

b. Abusive or Neglectful Situation : the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.

c. Danger to Others : the person's behavior and/or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

d. Danger to Self : a person's medical, psychiatric and/or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.

2. The Legislature has appropriated funds specific to individuals and/or to a specific class of persons.

F. If an eligible individual is placed on a waiting list for SLS waiver services, a written notice, including information regarding the client appeals process, shall be sent to the individual and/or his/her legal guardian in accordance with the provisions of Section S.057, et seq., of this Staff Manual.

8.500.95 ENROLLMENT

Community Centered Boards shall submit to the State the following document; enroll a person into the SLS program:

A. A copy of the Individual Choice Statement; and

B. A Copy of me Individualized Plan (IP); and

C. A Prior Authorization Request; and

D. A completed ULTC 100.2 and form.

An individual shall only be considered enrolled after prior authorization completed by the State and only for the time period approved.

8.500.97 SERVICE DESCRIPTIONS (Continued)

A. Personal Assistant Services (Continued)

3. Mentorship activities such as planning, decision-making, assistance with his/her participation on private and public boards, advisory groups and commissions, person specific training costs associated with providing unique supported living services to an individual, and child and infant care assistance for parent(s) who themselves have a developmental disability; and

4. Community accessibility services support the abilities and skills necessary to enable the individual to access the community and/or provide the basis for building skills which will assist the individual to access the community. These types of services include socialization, adaptive skills, personnel to accompany and support the individual in all types of community settings, supplies, travel including arranging and providing transportation, and providing necessary resources for participation in activities and functions in the community.

B. Professional Services

Professional services are those services, including evaluation and assessment, provided for a person with a developmental disability which require the service provider to be licensed or

certified in a particular occupational skill area such as an occupational therapist, registered nurse, speech/language pathologist, psychologist, etc.

The following types of professional services can be included under this waiver when they are not available under the regular Medicaid State Plan or third party payment:

1. Communication services to maintain or improve communication skills such as speech/language therapy, or interpreter services;

2. Counseling services including individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations;

3. Therapeutic services such as occupational or physical therapy including diagnostic evaluations or consultations needed to sustain the overall functioning of an individual; and

4. Personal care functions requiring professional care by an RN, LPN, Physician's Assistant or other such licensed or certified medical personnel. This may also include operating medical equipment.

C. Dental Services

Dental costs when dental problems are sufficient to lead to more generalized disease due to infection or improper care or nutrition. *(Note: The intent of this service is to provide, at a minimum, routine preventative dental care).*

D. Habilitation Services

Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

1. Specialized habilitation services focus on enabling the individual to attain his or her maximum functional level, and are coordinated with any physical, occupational, or speech therapies listed in the Individualized Plan. These services include such training as self-feeding, toileting, and self-care, self-sufficiency and maintenance skills. These services are highly therapeutic in nature, highly individualized with sensory stimulation and integration as major components.

   In addition, specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

2. Pre-vocational services not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Pre-vocational services are available only to individuals who have previously been discharged from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Nursing Facility (NF) or ICF/MR.

   Pre-vocational services are designed to assist individuals with developmental disabilities in acquiring and maintaining work habits and work-related skills. Pre-vocational services are intended to have a more generalized result as opposed to vocational training for a specific job. Individuals must have a demonstrated earning capacity of less than 50 percent of the federal minimum wage, as determined in accordance with certification standards promulgated by the U.S. Department of Labor.

Pre-vocational services encompass the following types of work-related activities:

a. teaching an individual such concepts as following directions, attending to task, task completion, communication, decision-making, and problem -solving; and

b. training in the areas of safety, self-advocacy, and mobility; and

c. intervention and training needed to benefit from prevocational services which would allow common barriers to participation to be avoided; and

d. travel training services may include providing, arranging, transporting, or accompanying a person with developmental disabilities to pre-vocational services and supports identified in the Individualized Plan. When compensated, individuals are paid at less than 50 percent of the minimum wage.

3. Supported Employment/Community Integrated Employment (CIE) services and supports are paid employment in an integrated work setting for individuals with developmental disabilities for whom competitive employment at or above the minimum wage is unlikely and who because of their disabilities need considerable ongoing support to perform in a regular work setting. A variety of regular work settings are used, particularly worksites in which persons without disabilities are employed.

   Community Integrated Employment services and supports encompass the following types of activities designed to assist eligible individuals to access and sustain employment in a regular work setting:

   a. individualized assessment which may include community orientation and job exploration; and

   b. individualized job development and placement services that produce an appropriate job match for the individual and his/her employer; and

   c. ongoing support, training, and facilitation in obtaining a job, job skill acquisition, job retention, career development, and work-related activities; and

   d. intervention and training needed to benefit from community integrated employment services and other supports which would help to remove or diminish common barriers to participation in employment and the building of community relationships; and

   e. travel services may include providing, arranging, transporting, or accompanying a person with developmental disabilities to services and supports identified in the Individualized Plan.

4. The activities provided under the definition of community integrated employment services and supports are not typically available as Section 110 services. Community Integrated Employment services and supports will provide supplemental and additional support to Colorado Rehabilitation Services during the time an individual receives transition services. Community Integrated Employment services and supports will provide long-term support for post-Colorado Rehabilitation Services, The services provided under the waiver are different from those provided by Colorado Rehabilitation Services.

   a) Community Integrated Employment services and support are available only to individuals who have previously been discharged from a Nursing Facility (previously called a skilled nursing facility) or Intermediate Care Facility for the

Mentally Retarded (previously called an Intermediate Care Facility).

b) Community Integrated Employment specifically excludes incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer o beneficiaries to encourage or subsidize employer's participation in a community integrated employment program; or

2. Payments that are passed through to beneficiaries of community integrated employment programs; or

3. Payments for vocational training that is not directly related to a beneficiary's community integrated employment program.

4. Transportation may be provided between the recipient's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the recipient receives habilitation services in more than one place) as a component part of habilitation services. When this cost is identified in the Individualized Plan, the cost of this transportation may be included in the rate paid to providers of the appropriate type of habilitation services.

E. Environmental Engineering

Environmental engineering consists of devices and adaptations identified in the Individualized Plan which are necessary to overcome environmental barriers which people with disabilities face in their daily lives, whether in their home or in their community. Such devices or adaptations minimize or eliminate the need for ongoing human assistance.

Environmental engineering can be included under this waiver when such devices or adaptations are not available under the regular Medicaid State Plan or third party payment.

Environmental engineering is available to make daily living easier by adapting or supplementing the person's environment through such means as:

1. Adaptations to living quarters including showers, toilets, control switches for the home, kitchen equipment for the preparation of special diets and accessibility such as ramps and railings; and

2. Mobility devices to help people move around including wheelchairs (general use and customized) and van adaptations; and

3. Expressive and receptive communication augmentation including electronic communication boards; and

4. Skill acquisition supports which make learning easier including adapted computers, games, or age appropriate toys; and

5. Safety enhancing supports including security or emergency response systems, and specialized clothing (e.g., Velcro) if the cost is above and beyond that of normal personal needs expenses; and

6. Specialized medical equipment, nondurable medical equipment and supplies; and

7. Assessing the need for, arranging for, providing and maintaining such devices and/or adaptations.

Excluded items and services shall include those adaptations or devices for the person's environment which are not associated with a direct medical or remedial need of the individual such as carpeting, roof repair, central air conditioning, regular clothing, etc. All devices and adaptations shall be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design and installation.

Environmental engineering is limited to a maximum of $10.000 per individual within the duration of this waiver except that on a case-by-case basis the State may prior authorize additional funds for any individual.

8.500.98 SERVICE PROVIDERS

A. Supported Living Services shall be provided by or through agencies that meet the following criteria:

1. Have been designated by the Department of Human Services, Developmental Disabilities Services to be a Community Centered Board; and

2. Have received and/or maintained program approval from the Department of Human Services, Developmental Disabilities Services for the provision of Supported Living Services; and

3. Have a Medicaid Provider Agreement; and

4. Have agreed to comply with all the provisions of Title 27,Article 10.5, C.R.S. (1995 Supp.), and the rules and regulations promulgated there under, including cooperation with the following activities:

   a. All State authorized on-site program reviews, whether for the purpose of program approval, on-going program monitoring, or State-initiated financial and program audits; and

   b. All State efforts to collect and maintain information on the SLS waiver program, whether required for federal or state program review and evaluation efforts, including information collection; and

   c. Any federal program reviews and financial audits of the SLS waiver program; and

   d. County Departments of Social/Human Services shall be authorized access, as required, to the records of persons receiving services held by case management agencies to determine or re-determine Medicaid eligibility; and

   e. All efforts by the case management agency to review the provider's programs, either generally or specifically for particular persons receiving services; and

   f. All long-term care determinations and continued stay reviews conducted by the Department of Human Services/Developmental Disabilities Services Utilization Review Contractor.

B. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.500.99 INDIVIDUAL RIGHTS

The rights of a person receiving Supported Living Services are established in Title 27, Article 10.5, Sections 112 through 131, C.R.S. (1995 Supp.), and the rules and regulations regarding these rights are promulgated with the Department of Human Services, Developmental Disabilities Services, rules and regulations, Chapter 6.

8.500.100 APPEAL PROCESS

An individual receiving SLS waiver services has a right to the appeal process established in the Department of Human Services, Developmental Disabilities Services, rules and regulations, Section 7.2 and 10 CCR 2505-10, Section 8.057.

8.500.101 QUALITY ASSURANCE

A. The monitoring of services provided under the Supported Living Services waiver and the health and well-being of service recipients shall be the responsibility of the Department of Human Services, Developmental Disabilities Services, under the oversight of he Department of Health Care Policy and Financing.

B. The Department of Human Services, Developmental Disabilities Services shall conduct on-site surveys or cause to have on-site surveys to be done in accordance with guidelines established by Developmental Disabilities Services. The survey shall include a review of applicable Colorado Department of Human Services, Developmental Disabilities Services rules and regulations and standards for SLS.

C. The Department of Human Services, Developmental Disabilities Services, shall ensure that the case management agency/community centered board fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with assurances required of these programs.

D. The Department of Human Services, Developmental Disabilities Services, shall maintain or cause to be maintained, for three years, complete files of all records, documents, communications, survey results, and other materials which pertain to the operation and service delivery of the SLS waiver program.

E. Developmental Disabilities Services shall recommend to the Department of Health Care Policy and Financing the denial and/or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to Developmental Disabilities Services within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

F. After receiving the denial and/or termination recommendation and reviewing the supporting documentation, the Department of Health Care Policy and Financing shall take the appropriate action.

8.500.102 POST ELIGIBILITY TREATMENT OF INCOME (PETI)

For individuals who are determined to be Medicaid eligible for the SLS waiver through the application of the 300% income standard as described at §8.110.8, the case manager shall allow an amount equal to the 300% standard as the personal maintenance allowance (no other deductions are necessary). The PETI assessment form shall be completed monthly by the case management agency to ensure that the individual's income does not exceed the maximum allowed for continued eligibility.

8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (CES)

8.503 DEFINITION

A. The Children's Extensive Support (CES) waiver services are provided through a 1915(c) Home and Community-Based Services Waiver for children who have a developmental disability, or for children under the age of five who are at risk of a developmental delay, in an Intermediate Care Facility for the Mentally Retarded (ICF/MR); or who are at risk of institutionalization and are subject to the availability of appropriate services and supports within existing resources.

B. The services provided under this program serve as an alternative to ICF/MR services for children from birth through seventeen years of age who meet the targeting criteria and the Level of Care Screening Guidelines. Services provided through this Children's Extensive Support Waiver (CES) shall be provided in the home or community when deemed appropriate and adequate by the child's physician, and shall be limited to:

1. Personal Assistance; and

2. Home Modification; and

2. Home Modification; and

3. Specialized Medical Equipment and Supplies, and

4. Professional Services; and

5. Community Connections.

8.503.10 PROGRAM ADMINISTRATION

A. CES services or children with developmental disabilities shall be provided in accordance with these rules and regulations.

B. The Children's Extensive Support waivers for children with developmental disabilities shall be administered by the Department of Human Services, Developmental Disabilities Services under the oversight of the Department of Health Care Policy and Financing.

C. CES waiver services do not constitute an entitlement to services, from either the Department of Health Care Policy and Financing or the Department of Human Services.

1. CES waiver shall be subject to annual appropriations by the Colorado General Assembly.

2. The Department of Human Services, Developmental Disabilities Services shall limit the utilization of the Children's Extensive Support waivers based on the federally approved capacity and cost effectiveness of the waiver and the total appropriations, and shall limit the enrollment when utilization of the CES waiver program is projected to exceed the spending authority.

D. Designated Community Centered Boards will be responsible for performing all functions related to the provision of the Children's Extensive Support waiver, pursuant to 27-10.5-105, et seq, C.R.S. (1995 Supp.).

8.503.20 PROGRAM PROVISIONS

Colorado requested and was granted authority to provide the following services under Children's Extensive Support waivers:

A. CES services shall be provided as an alternative to institutional placement for children with developmental disabilities and include personal assistance, home modification, specialized

medical equipment and supplies, professional services, and community connection services.

B. The Children's Extensive Support program is waived from the requirements of Section 1902(a)(10)(B) (comparability of services) and Section 1902(a)(l) (statewideness) of the Social Security Act Therefore, the availability and comparability of services may not be consistent throughout the State of Colorado.

C. Children eligible for services under the CES waivers shall be eligible for all other Medicaid services for which they qualify and shall first access all benefits available under the regular Medicaid State Plan and/or Medicaid EPSDT coverage prior to accessing funding for those same services under the CES waivers.

D. Case management agencies shall provide case management services under administrative activity including: assessment of the individual's needs to determine if CES waiver services are appropriate; completion of the Individualized Plan (IP); and submission of the Individualized Plan to the Department of Human Services, Developmental Disabilities Services, for review and approval for CES waiver services. These Individualized Plans shall be subject to review by the Department of Health Care Policy and Financing.

D. The provision of Children's Extensive Support services may be subcontracted by the CES agency to other qualified agencies, professionals, individuals or vendors in order to provide additional opportunities for individual choice and the use of general services.

E. The individual receiving services and/or his/her designated client representative, family or guardian are responsible for cooperating in the determination of financial eligibility, including prompt reporting of changes in income or resources; cooperating with the case management agency and service providers as agreed to in the Individualized Plan; and choosing between CES waiver services and institutional care.

8.503.30 ELIGIBILITY

A. Children who meet all of the following program eligibility requirements will be determined eligible:

1. The child has not reached his/her 18th birthday; and

2. The child is living at home with his/her biological, adoptive parent(s) or guardian, or is in an out-of-home placement including an ICF/MR, hospital or nursing facility and can be returned home with the provision of CES services; and

3. The child, if age five or older, has a developmental disability; or if less than five years of age, has a developmental delay, as determined by a community centered board (CCB); and

4. Children enrolled in the 1915(c) waiver shall be eligible for Supplemental Security Income (SSI).

5. The quality and quantity of medical services and supports identified in the Individualized Plan (IP) are provided pursuant to a physician’s order to meet the needs of the child in the home setting and

6. The income of the child shall not exceed 300% of the current maximum SSI standard maintenance allowance and

7. The resources of the child shall not exceed the maximum SSI allowance and

8. Enrollment of a child under this rule shall result in an overall savings when compared to the

ICF/MR cost as determined by the State and

9. The Utilization Review Contractor (URC) certifies that the child meets the Level of Care for ICF/MR placement; and

10. The child demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of medical status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically age appropriate and due to one or more of the following conditions:

    (a) A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life threatening condition/situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others is evidenced by actual events and the events occurred within the past six months.

    (b) Significant pattern of serious aggressive behaviors toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events, and the events occurred within the past six months.

    (c) Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.

11. The above conditions shall be evidenced by parent statement/data that is corroborated by written evidence that:

    (a) The child's behavior(s) or medical need(s) have been demonstrated; or

    (b) In the instance of an annual reassessment, it can be established that in the absence of the existing interventions or preventions provided through the CES Waiver that the intensity and frequency of the behavior or medical need would resume to a level that would meet the criteria listed above.

    (c) Examples of acceptable evidence shall include but not be limited to any of the following: medical records, professional evaluations and assessments, educational records, insurance claims, Behavior Pharmacology Clinic reports, police reports, social services reports or observation by a third party on a regular basis.

12. The child receives at least one waiver service each month.

B. Pursuant to the terms of the Children's Extensive Support Waiver (CES), the number of individuals who may be served each year in the CES Program shall be limited to the federally approved capacity of the waiver.

8.503.40 WAITING LIST PROTOCOL

A. Children determined eligible for services under the CES Program, which are not immediately available within the federally approved capacity limits of the waiver, shall be eligible for placement on a waiting list in the order in which the Utilization Review Contractor received the eligible application. Applicant children denied program enrollment shall be informed of their appeal rights in accordance with Section 8.057 of this manual.

B. When an opening/slot becomes available, the first child on the waiting list shall be reassessed for eligibility by the Utilization Review Contractor and, if determined to still be eligible, shall be assigned that opening/slot.

8.503.50 RESPONSIBILITIES OF THE COUNTY DEPARTMENT OF SOCIAL/ HUMAN SERVICES

A. The County Department of Social/Human Services shall obtain an application for medical assistance, including an MS-10 form for private insurance coverage, from each applicant, not already Medicaid eligible, through his/her parent or guardian. In addition, the County Department of Social/Human Services shall obtain or determine and record all of the following on initial enrollment and at least annually thereafter, or more frequently if necessary due to changes in income, medical or living situation:

1. Written confirmation from the District Office, Social Security Administration, that the applicant is eligible or ineligible for SSI payments due to the deeming of parental income and/or resources; or

2. Written confirmation from the District Office, Social Security Administration that the applicant is ineligible for SSI payments due to the child's own income and/or resources level; and Certification that the applicant's own income does not exceed 300% of the current SSI standard maintenance allowance on a monthly basis.

B. In the event that the County Department of Social/Human Services is able to provide sufficient documentation to recommend approval of eligibility, either at the time of the initial application or during the redetermination process, the County Department shall notify the family in writing and forward a copy, within fifteen (15) working days, to the Community Centered Board (CCB), the recognized case management agency in the family service area.

C. In the event that the County Department is unable to obtain sufficient documentation to recommend approval of eligibility, either at the time of the initial application or during the redetermination process, the County Department shall deny the applicant's request. The County Department shall notify the applicant, his/her parents or guardian in writing of the denial and of the applicant's right to an appeal in accordance with the procedures found in the Colorado Department of Human Services Income Maintenance Staff Manual (9 CCR 2503-1) Administrative Procedures

1. The County Department shall notify the case manager within five (5) working days of any changes in the child's income, which affect the applicant's eligibility status.

2. An applicant shall not be enrolled in the program or have his/her name placed on the waiting list without a case manager being assigned to the case by a CCB.

8.503.60 RESPONSIBILITIES OF THE COMMUNITY CENTERED BOARD

The Community Centered Board (CCB) shall make a determination of eligibility for developmental disabilities services for any child interested in applying for the CES Program.

8.503.61 DEFINITIONS

8.503.62 Case management services shall be defined as assistance on behalf of an eligible recipient to secure other needed services and supports to enable him/her to remain at home or in a non-institutional setting as an alternative to ICFMR placement when it is cost-effective to do so. Case management services shall include the following:

1. Documenting that the child's eligibility for Home and Community Based Services has been determined; and

2. Assessing the child's health care and social needs for CES services; and

3. Developing and implementing an Individualized Plan [§8.507.70]; and

4. Developing an Individual Support Plan (ISP) of services and projected costs [§8.507.80]; and

5. Coordinating and monitoring service delivery; and

6. Evaluating the effectiveness of services provided in the Plan; and

7. Reassessing the child's eligibility and need for CES services; and

8. Ensuring the child's parents) or guardian is informed of all Medicaid services available to the child including EPSDT Program services; and

9. Notifying the child's parents/guardian of adverse actions and appeal rights on a Department-designed form at least ten (10) calendar days prior to the effective date of such action.

Case management agency shall be defined as the Community Centered Board (CCB) in the service area where the child and family reside which has been approved through the Department of Human Services.

8.503.63 RESPONSIBILITIES OF THE CASE MANAGEMENT AGENCY

A. A child's parent(s) or guardian may request assistance applying for the CES Program from the CCB or County Department of Social/Human Services in their service area.

B. Upon receipt of a referral, the CCB shall be responsible to provide the following services:

1. Arrange for a case manager to be assigned; and

2. Inform the parent(s) or guardian of the purpose of the CES Program, the eligibility process, the minimum documentation required and the necessary agencies to contact; and

3. Begin assessment activities within ten (10) calendar days of receipt of the referral; and

4. Assist the parent(s) or guardian in completing the CES Application Packet and ensure completion of the ULTC-100 form; and

5. Arrange for and complete at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible, within thirty (30) calendar days of receipt of the referral; and

6. Refer the child, as needed, to the County Department of Social/Human Services to determine eligibility for Medicaid or other services and benefits as appropriate, e.g., the EPSDT Program, and deliver services in coordination with the County Department; and

1 Ensure that the child has been determined to meet the eligibility criteria for developmental disabilities services, and has a denial letter, if necessary, for SSI benefits; and

2. Submit the completed CES Application Packet Statement and the ULTC-100 form to the Utilization Review Contractor for an eligibility determination.

E. If there is an opening in the CES Program, the Utilization Review Contractor shall send an approved and date certified ULTC-100 form to the CCB. If the child has been on the waiting list, the

Utilization Review Contractor shall first verify the continued eligibility of the child. The CCB shall notify the parent(s) or guardian and arrange for the development of the Individualized Plan (IP) and an Individualized Support Plan (ISP) within thirty (30) calendar days.

F. If the child is eligible but there is no opening in the CES Program, the Utilization Review Contractor shall notify the CCB that the child has been placed on the waiting list and the order in which the child was placed on the list. The CCB shall notify the parent(s) or guardian within ten (10) calendar days.

G. If the child is not Medicaid eligible, in his/her own right, and/or does not meet the level of care criteria, the case manager shall refer the child to the County Department of Social/Human Services or other community agencies for possible services, as appropriate, within ten (10) working days of notification of denial.

8.503.70 INDIVIDUALIZED PLAN

8.503.71 DEFINITION

An Individualized Plan (IP) shall include information about why the child requires services and supports. All services and supports required to meet the needs in the home shall be listed. The purpose and the expected outcome of the services shall be included in the IP.

8.503.72 CONTENT OF THE INDIVIDUALIZED PLAN

A. The Individualized Plan shall consist of a Child's Needs Section, a Plan Section and a Purpose Section.

1. Child's Needs Section shall identify and list specific (medical and/or behavioral) conditions and/or other areas in which services and supports are required to maintain the child in the community/home setting. The areas of need shall include, but not be limited to, the following:

   (a) Medical needs; and

   (b) Functional needs; and,

   (c) Home/environmental needs.

2. Plan Section shall identify and quantify all services and supports required to meet the needs of the child, including case management services. The service listing shall identify the payment sources (i.e. family or informal supports, parental out-of-pocket expenditures, private insurance).

3. Purpose Section shall be a statement of a measurable goal that the case manager, child's parent(s) or guardian and service providers expect to obtain during the period covered by the Individualized Plan.

B. The Individualized Plan shall include the date and signatures of both the case manager and parent or guardian of the child.

C. The case manager shall calculate the total costs to the CES Waiver, utilizing the Individual Support Plan (ISP) document. The costs to implement the Individualized Plan shall not include case management services.

8.503.73 REVISIONS TO INDIVIDUALIZED PLAN

A. When a change in the Individualized Plan results in an increase in the cost of services/supports being provided, the case manager shall seek telephone approval from the Department of Human Services (DHS)/Develop mental Disabilities Services (DDS) Medicaid Section. Final authorization is contingent upon submission of a revised Individualized Plan and Individual Support Plan (ISP) within ten (10) working days.

B. When a change results in a decrease in services/supports and the overall costs, a revised Individualized Plan and Individual Support Plan (ISP) shall be submitted the DHS/DDS Medicaid Section within ten (10) working days.

8.503.74 INDIVIDUALIZED SUPPORT PLAN (ISP)

8.503.75 DEFINITION

An individual support plan (ISP) provides an explanation of how the services/supports will assist the child to continue to reside within the family home. The plan shall provide a complete listing of CES services/supports to be provided to the child, including the frequency of the services/supports to the child, the agency providing the services/supports, and the cost of the services/supports.

8.503.76 PURPOSE

The purpose of the individual support plan shall be to:

A. Provide an assessment of non-CES services and natural supports that assist the child to continue to live in the family home; and

B. Identify the needs and preferences of the child/family which, when met, will allow the child to continue to live in the family home; and

C. Identify safety, nutritional and medical needs to be addressed; and

D. Develop a plan of services and supports from qualified CES providers, chosen by the individual/family, that enable the child to continue to live in the family home.

8.503.77 REIMBURSEMENT

Only services/supports specifically listed on the ISP shall be available for reimbursement under CES.

8.503.78 RELATIONSHIP BETWEEN ISP AND IP

A. The Individualized Plan (IP) shall be the overall coordinating service plan for children with developmental disabilities who are receiving or on a waiting list for services/supports funded by Developmental Disabilities Services (DDS).

B. The IP has many similar features to the ISP, i.e., evaluation and assessment of needs, description of services, etc. When appropriate, the IP can reference information included on the ISP, and vice versa, in order to reduce duplication of effort.

C. Children receiving other DDS funded services, in addition to CES, shall have the IP as the overall coordinating plan. Children receiving CES, as the sole service program shall have the ISP be the primary service plan while the IP shall contain all needed elements and reference the ISP as the service plan.

8.503.80 COST CONTAINMENT

8.503.81 DEFINITION

The cost containment function of the case manager shall be to ensure, on an individual child basis, the cost of providing CES services is a cost effective alternative compared to the equivalent cost of appropriate ICF/MR institutional level of care. The case manager shall identify costs as part of each Individualized Plan to be submitted to the Department of Human Services for review. The Department of Human Services shall be responsible for ensuring that, on average, each plan is within the federally approved cost containment requirements of the waiver.

8.503.82 REQUIREMENTS

A. If services must be added or units of service increased, the case manager shall submit a revised Individualized Plan including an ISP demonstrating continued cost-effectiveness.

B. The Department of Human Services shall approve or disapprove the revised maximum authorization for services within thirty (30) calendar days of receipt of the revised IP and ISP. If there is an emergency need, the case manager shall telephone the Developmental Disabilities Services Medicaid Section at the Department of Human Services and request an expedited review.

C. Children in the CES program shall continue to meet the cost containment criteria during subsequent periods of eligibility.

D. The case manager shall send a copy of the Individualized Plan and the Individual Support Plan to the primary physician for review. The primary physician must attest that in his/her opinion, the quantity and quality of care planned for the child in the community/home is sufficient for the child's needs by signing the Individual Support Plan and returning it to the COB.

8.503.90 DOCUMENTATION: Program Enrollment

A. The completed enrollment forms shall be submitted to the Developmental Disabilities Services Medicaid Section at the Department of Human Services within thirty (30) calendar days of receipt of the approved ULTC-100 form from the Utilization Review Contractor indicating that an opening has been designated for the child. A complete packet includes:

1. A copy of the Individual Choice Statement; and

2. A copy of the Individualized Plan; and

3. A copy of the Individual Support Plan; and

4. A copy of the Utilization Review Contractor approved ULTC-100 form.

B. After review by Developmental Disabilities Services, if all requirements are met, the Individual Support Plan shall be returned to the CCB with the authorization signature from the State.

C. The case manager shall submit the following enrollment forms to the County Department of Social/Human Services for activation of a State Medicaid Identification Number:

1. A copy of the Individual Choice Statement;

2. A copy of the State authorized Individual Support Plan;

3. A copy of the Utilization Review Contractor approved ULTC-100 form; and

4. A copy of the SSI denial letter, if needed.

D. The effective date/enrollment date shall be no earlier than the start date on the Utilization Review Contractor approved ULTC-100 form. An approved ULTC-100 form does not constitute Program Enrollment. No services may be authorized prior to the date of enrollment.

E. An Individualized Plan, ULTC-100, and Individual Support Plan shall be valid for no more than a twelve (12) month period.

8.503.100 SERVICE DESCRIPTIONS

A. Personal Assistance Services

1. Child Care Services:

   The temporary care of a child which is necessary to keep a child in the home and avoid institutionalization.

2. Personal Supports:

   Personal supports shall include assistance with bathing and personal hygiene, eating, dressing and grooming, bowel and bladder care, menstrual care, transferring, basic first aid, giving medications, operating and maintaining medical equipment for a child who cannot perform these functions alone due to the developmental disability or medical condition.

3. Household Services:

   Household services shall include assistance in performing housekeeping tasks, which, due to the needs of the child with a developmental disability, are above and beyond the tasks generally required in a home and/or increase the parent(s) ability to provide care needed by the child with a developmental disability.

B. Home Modification Services

1. Home modification services may include those services which assess the need for, arrange for and provide modifications and/or improvements to the family home of a child with a developmental disability to help ensure the child's safety, security and accessibility in the home and community.

2. Home modification services include devices and services to make daily living easier, such as adapted showers or toilets, adaptations that make places accessible such as ramps and railings, and reinforcing or fencing for the child's protection.

3. Home Modification Services shall exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. All services shall be provided in accordance with applicable State or local building codes.

C. Specialized Medical Equipment and Supplies:

Specialized medical equipment and supplies services shall be provided only if these services are not available under Medicaid EPSDT coverage, Medicaid State Plan, benefits, other third party liability coverage or other federal or state funded programs, services or supports.

1. Assistive Technology Services:

Assistive technology services shall include the evaluation of the child's need for assistive technology related to the disability; helping to select and obtain appropriate devices; designing, fitting and customizing those devices; purchasing, repairing or replacing the devices; and training the child and/or family to use the devices effectively.

Assistive technology services shall include devices and services that will help a child with a developmental disability and the child's family to overcome barriers related to the disability that they face in their daily lives. This may include the use of devices to help the child move around such as wheelchairs, wheelchair adaptations, and adaptations for vans (e.g., lifts for vans or roof storage for wheelchairs), devices that help the child communicate such as electronic communication devices; devices that make learning easier such as adapted games, toys or computers; and devices that control the environment such as switches.

2. Other Equipment and Supplies:

    a. Kitchen equipment required for the preparation of special diets if this results in a cost saving over prepared foods.

    b. General care items such as distilled water for saline solutions, supplies such as eating utensils, etc., required by a child with a developmental disability and related to the disability.

    c. Specially designed clothing (e.g., Velcro) if the costs over and above the costs generally incurred for a child's clothing.

D. Professional Services:

Professional services shall be provided only if these services are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, other third party liability coverage or other-federal or state funded programs, services or supports. Professional services shall include:

1. Counseling and therapeutic services including individual and/or group counseling, behavioral or other therapeutic interventions related to the child's disability, needed to sustain the overall functioning of the child with a developmental disability; and

2. Consultation and direct service costs for training parents and other care providers in techniques to assist in caring for the child's needs. This includes acquisition of information for family members of children with developmental disabilities from support organizations and special resource materials, e.g., publications designed for parents of children with developmental disabilities; and

3. Diagnostic, evaluation and testing services necessary to determine the child's health and mental status and the related social. psychological and cognitive needs and strengths, including genetic counseling and family planning; and

4. Personal care functions requiring assistance by an RN, LPN, Certified Nurse Aide or Home Health Aide and not otherwise available under Medicaid EPSDT coverage, third party liability coverage, or other state funded programs, services or supports. These services may also include operating and maintaining medical equipment.

E. Community Connection Services:

The Community Connector shall explore community services appropriate to the individual in their community, natural supports available to the individual, match and monitor community

connections to enhance socialization and community access capability. This shall include:

1. Recreational and Leisure Activities (for the child with a developmental disability). Recreational programs that allow the child with a developmental disability to experience typical community leisure time activities increase their ability to participate in these activities and develop appropriate physical and psychological-social skills. (This benefit shall be limited to S500 per year).

2. Recreational equipment, such as a floatation collar for swimming, a bowling ramp, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a child with a developmental disability.

8.503.110 MAINTENANCE OF CASE RECORDS

The case manager shall maintain a record of each child referred to the CES program. The record shall include the initial assessment materials, documentation of all contacts by the case manager, copies of the home health agency plan of care, if applicable, and documentation of the disposition of the referral.

A. For each CES child enrolled, the case manager shall create and maintain a case record including:

1. Identifying information; and

2. Documentation that eligibility for Medicaid has been determined by the County Department of Social/Human Services; and

3. Documentation of the Utilization Review Contractor's level of care determination; the child's initial assessment materials including a copy of the CES Application Packet, the Individual Choice Statement, documentation of the disposition of the referral, Individualized Plan, and the Individual Support Plan; SS1 denial letter, if applicable; and verification of eligibility for developmental disabilities services; and

4. Documentation of case management.

B. Case management agencies shall follow requirements and regulations contained in Section 8.409.33 in the Department of Health Care Policy and Financing Staff Manual, Volume 8.

C. Case activity, including documentation of monitoring shall be included in the case record. All services, including case management, shall be evaluated as to effectiveness in reaching the goal of the Individualized Plan.

D. Whenever the case manager fails to comply with any regulation for case management services for the CES Program, due to circumstances outside the case manager's control, the circumstances shall be documented in the case record.

8.503.120 REDETERMINATION OF ELIGIBILITY

Redetermination of eligibility for CES services shall be made as follows:

A. At least annually and one (1) month prior to the expiration of the ULTC-100 form, the case manager shall ensure that a new ULTC-100 form is submitted to the Utilization Review Contractor. The case manager shall initiate a level of care review more frequently when warranted by significant changes in the child's situation.

B. At least annually, the case manager shall document verification of the child's Medicaid eligibility with the County Department of Social/Human Services income maintenance technician.

C. If the child is not Medicaid eligible and/or does not meet the level of care criteria, the case manager shall refer the child to the County Department of Social/Human Services or other community agencies for possible services, as appropriate, within ten (10) working days of notification of denial.

8.503.121 REASSESSMENT

A reassessment to redetermine or confirm a child's eligibility for the CES Program shall be conducted, at a minimum, every twelve (12) months and the following shall be renewed/revised and sent to the Developmental Disabilities Services Medicaid Section at the Department of Human Services no later than fifteen (15) working days prior to the expiration of the previous/current ULTC-100 form:

A. ULTC-100 form;

B. Individualized Plan; and,

C. Individual Support Plan.

8.503.130 TRANSFER PROCEDURES BETWEEN CASE MANAGEMENT AGENCIES

A. The sending Case Management Agency (CMA) shall complete the following procedures to transfer a child to another CMA:

1. Contact the receiving case management agency by telephone and give notification that the child is planning to transfer, negotiate an appropriate transfer date and provide information; and

2. If it is an inter-county transfer, notify the income maintenance technician to follow inter-county transfer procedures as outlined in the Colorado Department of Human Services Income Maintenance Staff Manual (9CCR 2503-1), Inter-county Transfer Section 3.140.3; and

3. Forward copies of pertinent records and forms to the receiving case management agency within five (5) working days of the child's transfer; and

4. Notify the Utilization Review Contractor and the Developmental Disabilities Services Medicaid Section at the Department of Human Services of the transfer within thirty (30) calendar days, using a State-designed form.

B. For any CES child transferring to a new case management agency, the receiving case management agency shall complete the following procedure:

1. Conduct a face-to-face visit with the child within ten (10) working days of the child's transfer; and

2. Review and revise the Individualized Plan and the Individual Support Plan, and change or coordinate services and providers as necessary.

8.503.140 TERMINATION FROM CES

A. The child shall be terminated from the CES Program when one of the following occurs:

1. The child no longer meets any one of the eligibility criteria at 8.503.30 of these rules; or

2. The cost of services and supports provided in the home or community exceed the cost effectiveness of the program; or

3. The parent/guardian chooses ICF/MR rather than the CES program; or

4. The family chooses to discontinue the CES program (e.g., moves out of state, no longer needs the Medicaid coverage); or

5. The child enrolls into another HCBS waiver program or is admitted for a long term stay in an institution (e.g. hospital or NF); or

6. The child expires.

B. The case manager shall inform the child's parent(s) or guardian in writing on a form provided by the Department of the termination from the CES Program, ten (10) calendar days before the effective date of the termination; and shall inform the child's parent(s) or guardian of his/her appeal rights as contained in the HOME AND COMMUNITY BASED SERVICES - CLIENTS RIGHTS section of this Staff Manual.

C. Whenever a child is terminated from the CES Program, the case manager shall notify all providers listed on the Individual Support Plan within ten (10) working days prior to the effective date of termination; and shall notify the Utilization Review Contractor and the Developmental Disabilities Services Medicaid Section at DHS within ten (10) calendar days, on a State-designed form.

D. The case manager shall provide appropriate referrals to other community agencies, including the County Department of Social/Human Services, if the child needs continued assistance to remain in the community, within five (5) working days of written notice of termination.

E. The reasons for termination and all agency referrals shall be documented in the child's case record.

8.503.150 MONITORING AND COORDINATION

A. Case managers shall document whether and how the services provided are meeting the child's needs, as defined in the Individualized Plan and Individual Support Plan, and ensure that the child continues to meet cost containment criteria. This monitoring shall include conducting child, parent/guardian and provider interviews and reviewing cost data and any written reports received from service providers. The case manager shall, at a minimum; document at least once every two (2) months whether and how the services are meeting the individual's needs as defined in the IP.

B. Case managers shall be responsible to coordinate information with the parents) or guardian, primary physician, service providers, County Department of Social/Human Services, CCB, Social Security Administration and others, as necessary, to ensure the effective delivery of services and support for the child.

8.503.160 GENERAL CERTIFICATION PROCEDURES FOR CASE MANAGEMENT AGENCIES (CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM - CES)

A. All CMAs for the CES Program shall be Community Centered (CDHS). The procedures and certification standards shall be Regulations, Chapter 2 (2 CCR 503-1).

B. Community Centered Boards are required to apply for certification as a CES-Specific Medicaid provider and have a provider agreement with the Colorado Department of Human Services.

C. Case management agencies shall meet all standards in the case management program section of the Colorado Department of Human Services Rules and Regulations, Chapter 5 (2 CCR 503-1).

D. The qualifications for a case manager shall be those described in Department of Human Services, Developmental Disabilities Services Rules and Regulations, Section 15.6.4.

E. Case management agencies shall maintain records that document their claims for case management services.

8.503.161 RENEWAL OF CASE MANAGEMENT AGENCIES CERTIFICATION (CES)

Renewal of case management agencies certification shall be in accordance with established procedures of the Colorado Department of Human Services.

8.503.162 TERMINATION OR NON-RENEWAL OF PROVIDER AGREEMENTS WITH CASE MANAGEMENT AGENCIES (CES)

Termination or non-renewal of Provider Agreements with case management agencies (CES) shall be in accordance with established procedures of the Colorado Department of Human Services.

8.503.170 SERVICE PROVIDERS

Children's Extensive Support services shall be provided by or through agencies that meet the following criteria:

A. Have been designated by the Department of Human Services, Developmental Disabilities Services to be a Community Centered Board; and

B. Have received and/or maintained program approval from the Department of Human Services, Developmental Disabilities Services for the provision of Children's Extensive Support services; and

C. Have a Medicaid Provider Agreement; and

D. Have agreed to comply with all the provisions of Title 27, Article 10.5, C.R.S. (1995 Supp.), and the rules and regulations promulgated thereunder, including cooperation with the following activities:

1. All State authorized on-site program reviews, whether for the purpose of program approval, ongoing program monitoring, or State initiated financial and program audits; and

2. All State efforts to collect and maintain information on the CES waiver program, whether required for federal or state program review and evaluation efforts, including information collection; and

3. Any federal program reviews and financial audits of the CES waiver program; and

4. County Departments of Social/Human Services shall be authorized access, as required, to the records of persons receiving services held by case management agencies to determine or redetermine Medicaid eligibility; and

5. All efforts by the case management agency to review the provider's programs, either generally or specifically for particular persons receiving services; and

6. All long-term care determinations and continued stay reviews conducted by the Utilization Review Contractor.

E. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.503.180 INDIVIDUAL RIGHTS

The rights of a person receiving Children's Extensive Support services are established in Title 27, Article 10.5, Sections 112 through 131, C.R.S. (1995 Supp,), and the rules and regulations regarding these rights are promulgated in the Department of Human Services, Developmental Disabilities Services, rules and regulations, Chapter 6.

8.503.190 APPEAL PROCESS

An individual receiving CES waiver services has a right to the appeal process established in the Department of Human Services, Developmental Disabilities Services, rules and regulations, Section 7.2 and 10 CCR 2505-10, Section 8.057.

8.500.200 QUALITY ASSURANCE

A. The monitoring of services provided under the Children's Extensive Support waiver and the health and well-being of service recipients shall be the responsibility of the Department of Human Services, Developmental Disabilities Services, under the oversight of the Department of Health Care Policy and Financing.

B. The Department of Human Services, Developmental Disabilities Services shall conduct on-site surveys or- cause to have on-site surveys to be performed in accordance with guidelines established by Developmental Disabilities Services. The survey shall include a review of applicable Colorado Department of Human Services, Developmental Disabilities Services rules and regulations and standards for CES.

C. The Department of Human Services, Developmental Disabilities Services shall ensure that the case management agency/CCB fulfills its responsibilities in the following areas: development of me Individualized Plan, case management, monitoring of programs and services, and provider compliance with assurances required of these programs.

D. The Department of Human Services, Developmental Disabilities Services, shall maintain or cause to be maintained, for three years, complete files of all records, documents, communications, survey results, and other materials, which pertain to the operation and service delivery of the CES waiver program.

E. Developmental Disabilities Services shall recommend to the Department of Health Care Policy and Financing the denial and/or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to Developmental Disabilities Services within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

F. After receiving the denial and/or termination recommendation and reviewing the supporting documentation, the Department of Health Care Policy and Financing shall take the appropriate action.

8.503.210 POST ELIGIBILITY TREATMENT OF INCOME (PETI)

For individuals who are determined to be Medicaid eligible for the CES waiver through the application of the 300% income standard at 8.110.8, the case manager shall allow an amount equal to the 300% standard as the personal maintenance allowance (no other deductions are necessary). The PETI assessment form shall be completed monthly by the case management agency to ensure-that the individual's income does not exceed the maximum allowed for continued eligibility.

8.506 CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER PROGRAM

The Children's HCBS Waiver Program (formerly known as the Katie Beckett Waiver Program), is a waiver

program for disabled children who are at risk of institutionalization in a hospital or nursing facility and who would not otherwise be eligible for Medicaid due to parental income and/or resources.

The services provided under this program serve as alternatives to Medicaid hospital or nursing facility services for children, birth through seventeen (17) years of age, and who meet the established minimum criteria for hospital or nursing facility level of care as determined by the Utilization Review Contractor. The services provided through this Children's HCBS Waiver Program shall include all state plan Medicaid benefits and case management services. These services, when deemed to be appropriate and adequate by the child's physician, shall be provided in the home or community. The Children's HCBS Waiver Program shall be administered by the Colorado Department of Health Care Policy and Financing (the State).

8.506.10 Eligibility

8.506.11 Program Eligibility

A. Services shall be provided to children who meet all the following program eligibility requirements:

1. The child has not reached his/her eighteenth (18th) birthday; and

2. The child is living at home with parent(s) or guardian and is at risk of institutional placement, as determined by the Utilization Review Contractor; or is in an acute care hospital or nursing facility and can be returned home and safely cared for in the home, and the child's parent(s) or guardian choose to receive services in the home or community instead of an institution, with the provision of Children's HCBS Waiver Program services; and

3. The child's physician certifies that the quality and quantity of services and supports identified in the Care Plan are sufficient to meet the needs of the child in the home setting; and

4. The Utilization Review Contractor certifies, through the ULTC-100 (Long Term Care Client Assessment Certification and Transfer) form, in conjunction with the Pediatric Functional Assessment Instrument, that the child meets the established minimum criteria for hospital or nursing facility level of care; and

5. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs; and

6. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State; and,

7. The child receives a waiver service on a monthly basis.

8.506.12 Financial Eligibility

Services shall be provided to children who meet all the following financial eligibility requirements:

A. Parental income and/or resources will result in the child being ineligible for SSI; and

B. The income of the child does not exceed 300% of the current maximum SSI standard maintenance allowance; and

C. The resources of the child do not exceed the maximum SSI allowance; and

D. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, SSI

Financial Eligibility Requirements, Consideration of Trusts In Determining Medicaid Eligibility, Section 8.110.52 of this manual.

8.506.13 Repealed, effective August 1, 2005

8.506.2 Waiting List Guidelines

A. When an opening becomes available:

1. Children who are determined by the Utilization Review Contractor to have an exceptional or immediate medical need shall be given priority based on medical need and shall be placed at the top of the waiting list; The Utilization Review Contractor shall be responsible for reviewing the initial request, and should an immediate medical need be identified, conduct the final review to determine if the client is appropriate for placement on the waiting list.

2. Exceptional or immediate medical need means a life-threatening disease/illness or medical condition which requires acute medical intervention, as determined by the Utilization Review Contractor and such medical treatment is not considered to be experimental, and the child meets all other relevant eligibility criteria.

3. Children who are not determined to have an exceptional or immediate medical need shall be placed on a waiting list in the order in which the application is received by the Utilization Review Contractor.

   The first child on the waiting list shall be reassessed for medical and financial eligibility and, if determined to still be eligible, assigned the next available opening.

B. The Utilization Review Contractor is responsible for maintaining and monitoring the waiting list

C. The Utilization Review Contractor is responsible for noticing the case management agency that the child has been placed on the waiting list.

D. The Utilization Review Contractor shall assure that no more than 630 clients are served on the Program at any one time state-wide.

8.506.3 Roles and Responsibilities of the County Department

The County Department shall:

A. Assist in completing an Application for Assistance;

B. Obtain from the child's parent(s) or guardian an SSI Denial Letter which they have obtained from the Social Security Administration, District Office Responsible for making the determination which documents that the parent's income and/or resources would render the child ineligible for Medicaid if it were deemed available to him/her;

C. Certify that the child's income and/or resources does not exceed 300% of SSI;

D. Assist in completing an MS-10 (Recipient Insurance Information To Be Used By The Colorado Medicaid Program Form);

E. Ensure the parent(s) or guardian are informed of all state plan Medicaid benefits available to the child;

F. Provide a list of certified case management agencies; and

G. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility.

8.506.4 Documentation

A. In the event the County Department is able to provide the above documentation to recommend assessment, the following will occur:

1. Upon recommendation of assessment, the child's parent(s) or guardian must inform the County Department of the name of the certified Children's HCBS Waiver Program case management agency of their choice so the County Department can forward the assessment.

2. The County Department shall forward the assessment within fifteen (15) working days to the certified Children's HCBS Waiver Program case management agency of choice.

3. The County Department shall notify the case manager within five (5) working days of any changes in the child's income, which might affect the eligibility status.

B. In the event the County Department is unable to obtain the above documentation to recommend assessment, the following will occur:

1. The County Department shall deny the child's request; and

2. The County Department shall notify the child's parent(s) or guardian, in writing, of the denial and right to appeal in accordance with procedures found in the Colorado Department of Human Services Income Maintenance Staff Manual (9 CCR 2503-1), Administrative Procedures Section 3.830.

8.506.5 Case Management

Case management is assistance provided by a case management agency on behalf of an eligible child, which includes referral of needed Medicaid services and supports, including In-Home Support Services, to enable the child to remain in his/her community-based setting.

Case management agency is a public, private, or private for non-profit agency which is certified by the State in accordance with procedures found in the General Certification Standards for Case Management Agencies, Section 8.506.97, of the Children's HCBS Waiver Program rules, to provide services throughout the State.

8.506.51 Roles and Responsibilities of the Case Management Agency

Case management agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at 26-1-114, C.R.S., as amended.

The case management agency shall:

A. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact;

B. Ensure the parent(s) or guardian are informed of In-Home Support Services and all state plan Medicaid benefits available to the child;

C. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community based services (Individual Choice Statement). A signature is required on this State

designated form

D. Assist in completing the identification information on the ULTC-100.2 form; Submit the ULTC-100.2 to the Utilization Review Contractor to determine whether the level of care criteria is met;

E. Begin assessment activities within ten (10) calendar days upon receipt of the referral

Assess child's health and social needs to determine whether or not program services are both appropriate and cost effective;

E. Verify that the child meets the appropriate level of care (hospital or nursing facility) criteria as determined by the Utilization Review Contractor;

F. Arrange for and complete at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible within thirty (30) calendar days of receipt of the referral;

G. Initiate a new level of care review by telephoning the Utilization Review Contractor should the face-to-face contact indicate that the child is more independent/functional than is indicated by the information on the certified ULTC-100.2, or that the child's medical condition has improved;

H. Notify the child's parent(s) or guardian and arrange for the development of the Care Plan and Prior Approval Cost Containment Record within thirty (30) calendar days;

I. Develop a Prior Approval Cost Containment Record form of services and projected costs. The case manager must identify costs as part of the Care Plan and the Cost Containment Record to be submitted to the State for review. The State shall be responsible for ensuring that, on average, each Care Plan is within the level of care State cost containment requirements. Approval of the Cost Containment Record form does not constitute automatic Medicaid reimbursement for Authorized Services identified. State An approval only makes sure that the cost of services does not exceed the equivalent cost of appropriate institutional care;

J. Develop and submit the In-Home Support Services Authorization as described in §8.552.3, In-Home Support Services, Program Eligibility;

K. Submit a copy of the approved Enrollment Form to the County Department for activation of a Medicaid State Identification Number;

L. Notify the child's parent(s) or guardian within ten (10) calendar days that the child has been placed on the waiting list;

M. Document whether and how the services provided are meeting the child's needs, as defined in the Care Plan, and ensure that the child continues to meet cost containment criteria;

N. Evaluate effectiveness by monitoring services provided to the child in meeting the needs stated in the Care Plan. This monitoring shall include conducting child, parent(s) or guardian, and provider interviews and reviewing cost data and any written reports received. Such evaluations shall be performed at the discretion of the case manager, but no less frequently than quarterly;

O. Complete a reassessment of each child, at a minimum, every twelve (12) months before the end of the length of stay assigned by the Utilization Review Contractor. A ULTC-100.2 may be valid for no more than a 12 month period.

P. Submit a care Plan and Prior Approval Cost Containment Record to the State demonstrating continued cost-effectiveness whenever a change in the Care Plan results in an increase or change in the services to be provided.

8.506.6 Roles and Responsibilities of the Utilization Review Contractor

The Utilization Review Contractor shall:

A. Determine, at admission, that the level of care criteria is met in accordance with 8.506.11,A,4.;

B. For continued stay review, renew or deny child assessment based on a twelve (12) month reassessment process;

C. Maintain and monitor the waiting list (Utilization Review Contractor only);

D. Notify case management agency when there is a Program opening;

E. Notify the child's parents) or guardian, the County Department, case management agency, and the State, in writing, if the child does not require the level of care provided in an institution, and of the child's right to an appeal.

8.506.7 Care Plan

8.506.71 Definition

The Care Plan is a document that identifies how services and supplies provided will meet the child's needs.

The supplies that are identified are described in quantifiable terms. All service required to meet these needs in the home or community shall be listed. The purpose and the expected outcome of the services shall be included in the Care Plan.

8.506.72 Requirements of Care Plan

A. The Care Plan shall consist of a Needs Section, Plan Section, and Purpose Section.

1. Needs Section shall identify and list specific (medical) conditions and needs for which services, supplies, and providers are required to maintain the child in the home or community. The areas of need shall include, but not be limited to, the following:

    a. medical needs;

    b. functional needs; and

    c. home/environmental needs.

2. Plan Section shall identify and quantify all services and suppliers required to meet the needs of the child, including case management and In-Home Support Services. The plan shall include a process, developed in coordination with the child's family and the child's physician, by which the child may receive necessary care if the client's family or care provider is unavailable due to an emergency situation or to unforeseen circumstances. The service listing shall identify payment sources (i.e., family or informal supports, parental out-of pocket expenditures, private insurance, case management costs).

3. Purpose Section shall be a statement of a measurable goal that the case manager, child's parent(s) or guardian and service providers expect to obtain during the period covered by the Care Plan.

B. The case manager shall send a copy of the Care Plan and Signature Page to the parent(s) or

guardian. The parent(s) or guardian must review and approve the Care Plan. The parent(s) or guardian must sign and date the Signature Page and return it to the case manager.

C. The case manager shall send a copy of the Care Plan and Signature Page to the child's physician. The physician must review the Care Plan and attest that, in his/her opinion, the quantity and quality of care planned for the child in the home or community is sufficient for the child's needs, and that such care/services can be safely and adequately provided by the caregiver. The physician must sign and date the Signature Page and return it to the case manager.

D. If a child is enrolled in more than one children's program and case management services are an authorized benefit, the case management agencies shall collaborate and specify in the Care Plan their unduplicated roles, responsibilities, and the services to be provided by each case management agency.

5.506.73 Revisions to Care Plan and Prior Approval Cost Containment Record

A. When a change results in an increase in the cost of services/supplies being provided, the case manager may seek telephone approval from the State. Approval is contingent upon submission of a revised Care Plan, and Prior Approval Cost Containment Record and Authorization for In-Home Support Services within ten (10) working days of telephone approval.

B. When a change results in a decrease in the cost of services/supplies being provided, no revision to the Care Plan or Prior Approval Cost Containment Record is necessary.

8.506.80 Cost Containment

8.506.81 Definition

The Prior Approval Cost Containment Record is a document that identifies the cost effective alternative compared to the equivalent cost of appropriate institutional (hospital or nursing facility) level of care.

8.506.82 State Calculation of Cost Containment Amount

For each level of care, the cost to Medicaid, on a per capita basis, is equal to or less man institutional (hospital or nursing facility) costs.

The State shall annually compute me equivalent monthly cost of nursing facility care in accordance with Section 8.485.100, HCBS-EBD, State Calculation of Cost Containment Amount.

The average daily per capita expenditures for acute care services to institutional (hospitalized) children shall be the per diem amount as reported on the most recent approved HCFA 372 report. This figure shall be computed annually to be effective January 1 for the current calendar year.

8.506.83 Requirements of Cost Containment Record

A. The Cost Containment Record shall include date and signature of the case manager.

B. The case manager shall determine that the total costs for services are less man or equivalent to the cost of appropriate institutional care, as calculated by the State, utilizing the Prior Approval Cost Containment Record. Such costs to implement the Care Plan shall include case management services.

8.506.84 Revisions to Cost Containment Record

The State shall approve or disapprove the revised maximum authorization for services within thirty (30)

calendar days of receipt of the revised Prior Approval Cost Containment Record.

8.506.9 Program Enrollment Documentation

A. Completed enrollment forms shall be submitted to the State within thirty (30) calendar days of receipt of the certified ULTC-100.2 form by the case manager from the Utilization Review Contractor indicating that an opening has been designated for the child. A complete packet includes:

1. Enrollment Form;

2. Individual Choice Statement/Signature Page;

3. Care Plan;

3. Prior Approval Cost Containment Record;

4. SSI Denial Letter which documents that the child is ineligible for Medicaid due to parental income and/or resources; and

6. Utilization Review Contractor's certified ULTC-100.2 form; and

7. In-Home Support Services Authorization.

B. After review by the State, if all requirements are met, copies of the Enrollment Form and Prior Approval Cost Containment Record will be returned to the case manager with the authorization signatures from the State.

C. The effective date/enrollment date shall be no earlier than the start date on the Utilization Review Contractor certified ULTC-100.2 form. A certified ULTC-100 form does not constitute program enrollment. No services, including case management, may be authorized prior to the date of Program enrollment.

D. An Enrollment Form, Care Plan, Individual Choice Statement/Signature Page, ULTC-100.2 and Prior Approval Cost Containment Record, and In-Home Support Services Authorization may be valid for no more than a twelve (12) month period.

8.506.91 Maintenance of Case Records

A. The case manager must create and maintain a case record for each child referred to the Children's HCBS Waiver Program. The case record must include:

1. Name, address, date of birth, phone number and any other identifying information about the child;

2. Documentation mat eligibility for Medicaid has been determined by the County Department;

3. Documentation of the Utilization Review Contractor's level of care determination (ULTC-100); Enrollment Form, initial assessment materials, including the Individual Choice Statement/Signature Page, documentation of the referral, Care Plan, Prior Approval Cost Containment Record, and SSI Denial Letter;

4. Documentation of case management;

5. Case activity, including documentation of monitoring. All services, including case management, shall be evaluated as to effectiveness in reaching me goal of the Care

Plan; and

6. Whenever the case manager fails to comply with any regulation for case management services for the Children's HCBS Waiver Program, due to circumstances outside the case manager's control, me circumstances must be documented in the case record.

8.506.92 Monitoring and Coordinating

A. Case managers shall document whether and how the services provided are meeting the child's needs, as defined in the Care plan, and ensure that the child continues to meet the cost containment criteria. Monitoring shall include conducting child, parent(s) or guardian and provider interviews and reviewing cost data and any written reports received from service providers. Case manager shall have, at a minimum, telephone contact with the child's parent(s) or guardian on a monthly basis. These contacts must be documented in the case file.

B. Case managers shall be responsible for coordinating information with the parents) or guardian, child's physician, service providers, County Department, Community Centered Board, and others, as necessary, to ensure the effective delivery of services and support for the child.

8.506.93 Reassessment

A. Reassessments are initiated by the case management agency, at a minimum, every twelve (12) months before the end of the length of stay on the ULTC 1002 form following Program Guidelines except for the Waiting List Guidelines outlined in Section 8.506.2.The following documents shall be renewed/revised and sent to the State no later man fifteen (15) working days prior to the expiration of the current ULTC 100.2 form:

1. Enrollment form;

2. ULTC 100.2 form;

3. Care Plan;

4. Prior Approval Cost Containment Record; and

5. Individual Choice Statement/Signature Page.

B. The case manager may initiate a level of care review more frequently, when warranted by significant changes in the child's situation.

C. The case manager must document verification of the child's Medicaid eligibility with the County Department. If the child is Medicaid eligible and meets the level of care criteria, the case manager shall conduct a reassessment in accordance with this section.

D. If the child is not Medicaid eligible and/or does not meet the level of care criteria, the case manager shall refer the child to the County Department or other community agencies for possible services, as appropriate, within ten (10) working days of notification of Children's HCBS Waiver Program denial.

8.506.94 Case Management Agency/Intercounty Transfer Procedures

A. The sending case management agency shall:

1. Contact the receiving case management agency by telephone and provide notification that, the child is planning to transfer (per parent(s) or guardian choice); negotiate an

appropriate transfer date, and forward case file to the receiving case Rev eff management agency;

2. Forward copies of pertinent records and forms to the receiving case management agency within five (5) working days of the child's transfer;

3. Notify the State and the Utilization Review Contractor of the transfer within thirty (30) calendar days, using a State designated form, indicating effective date, name of new case management agency, and type of transfer,

4. If an intercounty transfer, notify the income maintenance technician to follow intercounty transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual (9 CCR 2503-1), Intercounty Transfer Section 3.140.3.

B. The receiving case management agency shall:

1. Conduct a face-to-face visit with the child within ten (10) working days of the child's transfer;

2. Review and revise the Care Plan and the Prior Approval Cost Containment Record and change or coordinate services and providers as necessary.

8.506.95 Termination

A. The child shall be terminated from the Program when one of the following occurs:

1. The child no longer meets the level of care criteria for hospital or nursing facility placement as determined by the Utilization Review Contractor;

2. The physician can no longer certify that the quality and quantity of services and supports provided are able to meet the needs of the child in the home or community;

3. The child's own income and/or resources put him/her in excess of the allowable 300% of the SSI standard maintenance allowance or SSI personal assets limit;

4. The parent's income and/or resources decrease, and the child becomes Medicaid eligible without the use of the Children's HCBS Waiver Program;

5. The cost of services and supports provided in the home or community exceed the cost effectiveness guidelines of the Program;

6. Eighteen (18) years of age;

7. The parent(s) or guardian choose hospital or nursing facility services rather than the Children's HCBS Waiver Program services;

8. The family chooses to discontinue the Children's HCBS Waiver Program (e.g., moves out of state, no longer needs the Medicaid coverage); or,

9. The child expires.

B. The case manager shall notify all providers listed on the Care Plan within ten (10) working days of termination;

C. The case manager shall notify the State, Utilization Review Contractor, and the County Department, within ten (10) calendar days of termination, on a State designated form;

D. The case manager shall provide appropriate referrals to other community agencies, including the County Department, if the child needs continued assistance to remain in the home or community, within five (5) working days of written notice of termination;

E. The reason for termination and all agency referrals shall be documented in the child's case record;

F. The case manager shall inform the child's parent(s) or guardian in writing on a State designated form of the termination from the Children's HCBS Waiver Program, ten (10) calendar days before the effective date of the termination.

8.506.96 Client Rights

A. The case manager shall inform the child's parent(s) or guardian of the client's rights in accordance with procedures found in the HCBS-EBD, Client Rights Section, 8.485.300.

B. Children denied Program enrollment shall be informed of their appeal rights in accordance with procedures found in the Recipient Appeals Protocols/Process, Section 8.057 of this manual.

8.506.97 General Certification Standards for Case Management Agencies

A. Certification standards for the Children's HCBS Waiver Program case management agencies shall be the same as those prescribed for provider agencies in accordance with procedures found in the HCBS-EBD, General Certification Process Section 8.487.20.

B. Case management agencies operated by Community Centered Boards shall also meet the General Provisions set forth in the Community Centered Boards Section of the Department of Human Services, Developmental Disabilities Services, Rules and Regulations, Chapter 2 (2 CCR 503-1).

C. Case management agencies operated by Community Centered Boards shall also meet all standards in the Case Management Services Section of the Department of Human Services, Developmental Disabilities Services, Rules and Regulations, Chapter 5 (2 CCR 503-1).D. Case management agencies are required to apply specifically for certification as a Children's HCBS Waiver Program provider and have a Provider Agreement with the State.

E. Case management agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.506.98 Monitoring Process For Case Management Agencies

Case management agencies are subject to inspection, review and audit by the State Department.

8.506.99 Termination or Non-Renewal of Provider Agreements

Termination or non-renewal of Provider Agreements shall be in accordant: with procedures found in the HCBS-EBD, Termination or Non-Renewal of Provider Agreements Section 8.487.70.

8.506.100 Reimbursement For Case Management Services

Case management agencies shall bill the fiscal agent and shall be reimbursed for case management activity in fifteen minute increments.

8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

The Children's Habilitation Residential Program is a residential services and support program for children

and youth who are developmentally disabled as defined in Section 27-10.5-102 (11), C.R.S. (See 8.508.170, E.) Children under the age of five who are developmentally delayed are included only when their developmental delay is accompanied by significant medical and/or behavioral needs. The children are placed through Colorado County Departments of Social/Human Services. The children are at risk of institutionalization and the program serves as an alternative to placement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

The services provided through this program serve as an alternative to ICF/MR placement for children birth to twenty-one years of age who meet the eligibility criteria and the Level of Need Screening Guidelines. The services provided through the Children's Habilitation Residential Program (CHRP) shall be limited to :

Self-Advocacy Training

Independent Living Training

Cognitive Services

Communication Services

Counseling and Therapeutic Services

Personal Care Services

Emergency Assistance Training

Community Connection Services

Travel Services

Supervision Services

Respite Services

when deemed to be appropriate and adequate by the child's physician, and these services shall be provided in the community, as available.

CHRP services for children with developmental disabilities shall be provided in accordance with these rules and regulations.

8.508.10 PROGRAM ADMINISTRATION

A. The Children's Habilitation Residential Service Program for children with developmental disabilities is administered by the Colorado Department of Human Services (CDHS), Division of Child Welfare under the oversight of the Department of Health Care Policy and Financing.

B. CHRP services do not constitute an entitlement to services, from either the Department of Health Care Policy and Financing or the Department of Human Services.

C. CHRP services are subject to approval of a waiver under Section 1915c of the Social Security Act by the Center for Medicare and Medicaid Services.

D. CHRP services are subject to annual appropriations by the Colorado General Assembly.

E. The Department of Human Services, Division of Child Welfare shall limit the utilization of the CHRP

based on:

1. The federally approved capacity of the waiver;

2. Cost effectiveness (see Section 8.508.80); and

3. Within the total appropriation limitations when enrollment is, projected to exceed spending authority.

8.508.20 PROGRAM PROVISIONS

Colorado has authority to provide the following services under the CHRP:

A. CHRP services are provided as an alternative to institutional placement for children with developmental disabilities and are limited to self-advocacy training, independent living training, cognitive services, communication services, counseling and therapeutic services, personal care services, emergency assistance training, community connection services, travel services, and supervision services.

B. Children eligible for services under the CHRP waiver are eligible for all other Medicaid services for which they qualify and must first access all benefits available under the regular Medicaid State Plan and/or Medicaid EPSDT (Early and Periodic Screening, Diagnosis and Treatment) coverage prior to accessing funding for those same services under the CHRP.

C. Case management services will be provided by the county department as an administrative activity and include:

   1. Assessment of the individual's needs to determine if CHRP services are appropriate;

   2. Completion of the Individualized Plan (IP); and

   3. Submission of the Individualized Plan to the Colorado Department of Human Services, Division of Child Welfare Services, for review and approval for CHRP waiver services. These Individualized Plans are also subject to review by the Department of Health Care Policy and Financing.

D. The individual receiving services and his/her family or guardian and placing County Department of Social/Human Services are responsible for participating with the services provider in:

   1. Developing the Individualized Plan;

   2. Cooperating with implementation of the service plan;

   3. Choosing to receive services through the CHRP waiver.

8.508.30 ELIGIBILITY

A. Services shall be provided to children with developmental disabilities who meet all of the following program eligibility requirements:

   1. The child shall be determined eligible for developmental disabilities services by the appropriate Community Centered Board (CCB).

2. The child is a Colorado child placed in foster care through a Colorado County Department of Social/Human Services by court order. This includes children placed through a voluntary agreement with the Colorado County Department of Social/Human Services while awaiting the court to take jurisdiction.

3. Waiver services to individuals age eighteen to 21 will be provided if the individual is in a court-ordered foster care placement through the County Department of Social/Human Services and the court order is in effect when the child reaches his/her eighteenth birthday.

4. The child is at risk of or has been reported/found to be abused and/or neglected or dependent, as defined in 19-3-102, C.R.S.

5. The child shall meet the out-of-home placement criteria as defined in Section 7.304.3, Colorado Department of Human Services Social Services Staff Manual (12 CCR 2509-4).

6. The child shall meet the Target Group for Program Areas 4, 5, or 6 as outlined in 7.201.2, 7.202.2 and 7.203.21, Colorado Department of Human Services Staff Manual (12 CCR 2509-3).

7. The Level of Need checklist documents that the child/youth is in need of the services available through the waiver.

8. The CDHS CHRP waiver administrator verifies through the CHRP waiver eligibility process, including the ULTC 100 and LTC 102 - CHRP that the child meets the established minimum eligibility criteria for ICF/MR placement.

9. The child's eligibility for Supplementary Security Income (SSI) benefits is established.

10. The income of the child does not exceed 300% of the current maximum SSI standard maintenance allowance.

11. The resources of the child do not exceed the maximum SSI allowance.

12. The child's eligibility for Colorado Medicaid is established and reported in the Child Welfare automated system.

13. Enrollment of a child in the CHRP will result in an overall savings when compared to the ICF/MR cost as determined by the State.

14. The child receives at least one waiver service each month.

B. Pursuant to the terms of the Children's Residential Habilitation Program (CHRP), the number of individuals who may be served each year in the CHRP is based on criteria found in Section 8.508.10(E).

8.508.40 WAITING LIST PROTOCOL

Children determined eligible for services under the CHRP which are not immediately available within the federally approved capacity limits of the waiver shall be eligible for placement on a waiting list in the order in which the eligible application was received by the CDHS CHRP waiver administrator. Guardians of applicant children denied program enrollment shall be informed of their appeal rights in accordance with Section 8.057 of this Staff Manual.

When an opening becomes available, the first child on the waiting list shall be reassessed for eligibility by the CDHS CHRP waiver administrator and, if determined to still be eligible, assigned that opening.

8.508.50 RESPONSIBILITIES OF THE COUNTY DEPARTMENTS OF SOCIAL SERVICES

The County Department of Social/Human Services shall:

A. Ensure that the eligibility requirements as defined in 8.503.30, A, 1 through 8 are met;

B. Submit eligibility applications to the CDHS CHRP waiver administrator with a request for enrollment or placement on the waiting list.

C. Provide services to children in out-of-home placement and their families as required in CDHS Social Services Staff Manual (12 CCR 2509-4, 7.300 Child Welfare Services).

D. Determine whether a familial relationship as defined in 27-10.5-102, C.R.S. exits, between the licensed or certified provider and the child.

E. Determine prior to referring to CHRP, that the extraordinary service, needs of the child exceed the maximum reimbursement the County Department of Social/Human Services is able to negotiate based on the child's individualized needs as authorized in 26-5-104(6), C.R.S. The County Department of Social/Human Services must negotiate based on the child's. need and the service provider's ability to meet the needs.

F. Exhaust appropriate community services available to the children before requesting similar services from the waiver.

8.508.60 RESPONSIBILITIES OF THE COMMUNITY CENTERED BOARD

The Community Centered Board (CCB) shall make a determination of eligibility for developmental disabilities services for any child being considered for enrollment in the Children's Habilitation Residential Program who is referred by a County Department of Social/Human Services.

8.508.70 NDIVIDUALIZED PLAN (IP)

A written IP describes the medical and other services to be furnished, their frequency, and the type of provider who will furnish each.

8.508.71 CONTENT OF THE INDIVIDUALIZED PLAN

A. The Individualized Plan (IP) shall consist of a Child's Needs Section, a Plan Section, and an Expected Outcomes Section.

    1. Child's Needs Section shall identify and list specific conditions (needs) for which services and supports are needed to maintain the child in the community setting. The areas of needs shall contain and not be limited to:

        a. medical needs;

        b. functional needs; and

        c. safety needs.

    2. Plan Section shall:

        a. Identify and quantify all services and supports to be provided to meet the child's needs; and

b. Identify the name or type of provider of services;

c. Identify payment responsibilities for the services, e. g., Parent, County Department of Social/Human Services, CHRP.

3. Expected Outcomes Section shall be a statement of measurable objectives expected to be obtained during the period covered by the Individualized Plan.

B. The Individualized Plan shall include the date and signatures of the provider, the guardian, the County Department of Social/Human Services, and the child when appropriate.

C. The provider shall calculate the total costs to the Children's Habilitation Residential Program, utilizing Individualized Plan document The costs to implement the Individualized Plan shall not include room, board, and personal needs allowance.

8.508.72 REVISIONS TO INDIVIDUALIZED PLAN

A. When a change in the Individualized Plan results in an increase in the costs of services/supports being provided, the County Department of Social Services may seek telephone approval from the Department of Human Services, Division of Child Welfare Services. Final authorization is contingent upon submission and approval of a revised Individualized Plan to the Division of Child Welfare Services within ten working days. Continued cost effectiveness must be demonstrated when there is an increase in costs.

B. When a change results in a decrease in the costs of CHRP services, a revised Individualized Plan must be submitted to the CDHS, Division of Child Welfare Services within ten working days of the change.

C. CDHS shall approve or disapprove the revised maximum authorization of services within thirty (30) calendar days of receipt of the revised IP. If there is an emergency need, the provider shall telephone the CDHS, Division of Child Welfare Services and request an expedited review.

8.508.73 REIMBURSEMENT

Only services identified on the Individualized Plan are available for reimbursement under CHRP. Reimbursement will be made only to licensed or certified providers, as defined in Section 8.508.160 and services will be reimbursed on a daily rate basis through the Medical Management Information System (MMIS) for the habilitative services. Medicaid shall not pay for room and board. The equivalent of the full federal SSI benefit will provide for the room, board and personal needs allowance. Education costs will be reimbursed through the Department of Education and rot by the Colorado Department of Human Services or Medicaid.

8.508.80 COST CONTAINMENT

Cost containment is to ensure, on an individual child basis, that the provision of CHRP services is a cost effective alternative compared to the equivalent cost of appropriate ICF/MR institutional level of care. The provider must identify costs as part of each Individualized Plan to be submitted to the CDHS for review. The State shall be responsible for ensuring that, on average, each plan is within the federally approved cost containment requirements of the waiver. Children enrolled in the CHRP shall continue to meet the cost containment criteria during subsequent periods of eligibility.

A. The completed enrollment forms shall be submitted to the County Department of Social/Human Services CHRP waiver administrator. A complete packet includes a copy of the:

1. Individual Choice Statement.

2. Individualized Plan; within 30 calendar days.

3. Level of Need document.

4. ULTC 100.2 form.

5. Request for Enrollment.

B. The county department CHRP waiver administrator will immediately submit enrollment documentation to the CDHS CHRP waiver administrator for verification of eligibility. A complete packet includes a copy of the:

1. ULTC 100.2; and

2. Request for Enrollment; and

3. Individual Choice Statement

4. Individualized Plan within 45 calendar days.

C. The effective date/enrollment date shall be no earlier than the start date on the CDHS CHRP waiver administrator's ULTC 100.2 verification form. No services may be authorized prior to the date of enrollment

D. An Individualized Plan and ULTC 100.2 verification may be valid for no more man a twelve (12) month period.

8.508.100 SERVICE DESCRIPTIONS

A. Self-advocacy training may include training in expressing personal preferences, self-representation, individual rights and making increasingly responsible choices. It may also include team building with volunteers, professionals, and/or family members to examine changing roles as service models shift from the traditional supervision/control model to a self-actualization model.

B. Independent living training may include training in personal care, household services, child and infant care (for parents themselves who are developmentally disabled), and communication skills such as using the telephone, using sign language, facilitated communication, reading, and letter writing.

C. Cognitive services may include training with money management and personal finances, planning and decision-making.

D. Communication services may include professional training and assistance to maintain or improve communication skills. It may include a professional or individual who provides interpretation and facilitated communication services.

E. Counseling and therapeutic services may include individual and/or group counseling, behavioral or other therapeutic interventions directed at increasing the overall effective functioning of an individual.

F. Personal care services may include any personal care functions requiring training/assistance by an RN, LPN, or Certified Nurse Aide. It may also include operating, maintaining, and training in the use of medical equipment.

G. Emergency assistance training includes developing responses in case of emergencies, prevention

planning and training in the use of equipment or technologies used to access emergency response systems.

H. Community connection services may explore community services available to the individual, and develop methods to access additional services/supports/activities desired by the individual. Community connection services can provide the individual with the resources to participate in the activities and functions of the community desired and chosen by the individual receiving the services. Typically, these will be the same type of activities available and desired by the general population.

I. Travel services may include providing, arranging, transporting, or accompanying a person with developmental disabilities to services and supports identified in the IP.

J. Supervision services may include a person safeguarding an individual with developmental disabilities and/or utilizing technology for the same purpose.

K. Respite Services: Services that are provided to an eligible client on a short term basis because of the absence or need for relief of those persons normally providing the care. Respite services may be approved for up to 30 days a calendar year for each eligible client.

L. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code.

M. Only those services not available under Medicaid EPSDT, Medicaid State plan benefits, third party liability coverage, or other state funded programs, services or supports are available through the Children's Habilitation Residential Program (CHRP) Waiver. Appropriate community services must be exhausted before requesting similar services from the waiver. The CHRP Waiver does not reimburse services that are the responsibility of the Colorado Department of Education.

8.508.110 MAINTENANCE OF CASE RECORDS

A. Copies of the ULTC 100.2 shall be maintained by the County Department of Social/Human Services and the CDHS Division of Child Welfare Services. In addition, the County Department of Social/Human Services shall maintain a copy of the Individualized Plan and Level of Need Checklist for the Children's Habilitation Residential Program. A copy of the ULTC 100.2 verification form shall be maintained by the provider.

B. Copies of evaluations and re-evaluations shall be maintained for a minimum period of three years by those cited in 8.508.110, A, with the exception of providers who are required to maintain records for a period of six years from the date services are rendered.

C. Confidentiality of records shall be maintained in accordance with Section 8.100.8 of this manual, as well as with CDHS Social Services Staff Manual, Section 7.000.72 (12 CCR 2509-1).

D. Documentation of case activity shall also meet requirements of CDHS, Division of Child Welfare Services as outlined in the CDHS Social Services Staff Manual, Section 7.000.72 (12 CCR 2509-1).

8.508.120 REDETERMINATION OF ELIGIBILITY

Redetermination of eligibility for CHRP services shall be made as follows:

A. At least annually and one (1) month prior to the expiration of the ULTC 100.2 form, the County

Department of Social/Human Services CHRP waiver administrator shall ensure that a new ULTC 100.2 form is submitted to the CDHS CHRP waiver administrator for verification if there is no significant change in the child's condition.

B. At least annually, the County Department of Social/Human Services shall verify the child's continued Medicaid eligibility.

8.508.121 REASSESSMENT

A reassessment to redetermine or confirm a child's eligibility for the CHRP Program must be conducted, at a minimum, every twelve (12) months and the following shall be renewed/revised and submitted to the county department CHRP waiver administrator no later than one (1) month prior to the expiration of the previous/current ULTC 100.2 verification form:

A. Individualized Plan

B. Copy of the Level of Need worksheet

C. Copy of the ULTC 100.2

D. The county department CHRP waiver administrator shall submit a copy of the Individualized Plan to the CDHS CHRP waiver administrator.

8.508.130 TRANSFER PROCEDURES BETWEEN COUNTY DEPARTMENTS OF SOCIAL SERVICES

Transfer of cases shall occur in accordance with CDHS Social Services Staff Manual, Section 7.000.6, D (12 CCR 2509-1).

8.508.140 DISCONTINUATION FROM CHRP

A. A child shall be discontinued from the CHRP Program when one of the following occurs:

1. The child no longer meets one of the criteria as outlined in Section 8.508.30 of these rules;

2. The costs of services and supports provided in the community exceed the cost effectiveness criteria of the program;

3. The child enrolls in another HCBS waiver program or is admitted for a long-term stay in an institution (e.g., hospital); or

4. The child reaches his/her 21st birthday or transitions into DDS Adult Residential Services.

B. The County Department of Social/Human Services shall inform the child's parent(s) or guardian in writing on a form provided by the State of discontinuation from the CHRP Program, at least ten (10) calendar days before the effective date of discontinuation. The child's parent or guardian shall also be informed of his/her appeal rights as contained in the Home and Community Based Services - Client's Rights section of this Staff Manual. The reason and regulation supporting the discontinuation shall be clearly identified on this notice.

C. Whenever a child is discontinued from the CHRP, the County Department of Social/Human Services shall notify all providers listed on the IP within ten (10) calendar days prior to the effective date of discontinuation; and shall notify the CDHS Division of Child Welfare Services within ten (10) calendar days, on a State designed form.

D. The reason for discontinuation shall be documented in the child's case record.

8.508.150 MONITORING AND COORDINATION

A. County Departments of Social/Human Services shall document whether and how the services provided are meeting the child's needs, as defined in the IP. Documentation requirements shall be the same as those outlined in CDHS Social Services Staff Manual, Section 7.002.1 (12 CCR 2509-1), related to case planning.

B. County Departments of Social/Human Services shall be responsible to coordinate information with the parent(s) or guardian, primary physician, service providers, community centered boards, Social Security Administration and others as necessary to ensure the effective delivery of services to the child.

8.508.160 SERVICE PROVIDERS

A. Children's Habilitation Residential Program services shall be provided by the following residential provider types which shall meet all of the certification, licensing and Quality Assurance regulations related to the provider type as outlined in CDHS Social Services Staff Manual, Section 7.701 (12 CCR 2509-8):

1. Family Foster Care Homes, as defined by the waiver, and certified and supervised by County Departments of Social Services or Child Placement Agencies (CPAs).

2. Residential Child Care Facilities licensed through the CDHS Division of Child Care.

3. Specialized group facilities licensed by the Division of Child Care and supervised by County Departments of Social/Human Services or Child Placement Agencies.

B. Children's Habilitation Residential Program Service Providers may also include Providers as defined in Section 8.500.5 of this Staff Manual. Home and Community Based Services for the Developmentally Disabled (HCBS- DD) programs will be provided by agencies that meet the following criteria:

1. Have received and/or maintained program approval from the Colorado Department of Human Services, Division for Developmental Disabilities Services for the provision of HCBS-DD waiver services; and

2. Have a Medicaid Provider Agreement; and

3. Have agreed to comply with all the provisions of Title 27, Article 10.5, C.R.S. and all the rules and regulations promulgated thereunder; and

4. Have, if applicable, the current required license from the Colorado Department of Public Health and Environment.

C. Service providers shall cooperate in all of the areas identified in Section 8.500.52.

D. All eligible providers shall have a Medicaid Provider Agreement.

E. Provider agencies shall maintain liability insurance in at least such minimum amounts as set annually by the Department of Health Care Policy and Financing, and shall have written policies and procedures regarding emergency procedures.

F. Service providers shall not be family members as defined in §27-10.5-102(15), C.R.S. for the children they serve in the waiver.

G. When a qualified provider contracts with or utilizes the services of a professional, individual, or vendor to augment a child's services under the waiver the definitions and qualifications contained in Section 8.508.170 apply.

H. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.508.170 DEFINITIONS

Habilitative services are defined as those services which are recommended by a licensed practitioner, as defined in §26-4-527(3), C.R.S. to assist clients with developmental disabilities eligible under the State Plan to achieve their best possible functional level. All clients of Residential habilitation services and supports will receive some type of habilitation services in order to acquire, retain, or improve self- help, socialization, or other skills needed to reside in the community. Some clients may receive a combination of habilitative services (skill building) and support services (a task performed for the client, where learning is secondary or incidental to the task itself).

A. Assessment: The process of collecting and evaluating information for the purpose of developing an individual child plan on which to base services and referral. The assessment process is both initial and ongoing.

B. Case Management: Activities that are intended to ensure that clients receive the services they need, that services are coordinated, and that services are appropriate to the changing needs and stated desires of the clients and families over time. The goals of case management are: 1) to bring about positive changes in client's status; 2) to assist clients hi reaching their highest potential; and 3) to achieve the best possible quality of life for clients and their families in the community. Goals are developed to the extent possible among case managers, referral sources, families and clients.

C. Client: A child or youth who is receiving habilitative services in the Children's Habilitation Residential Program.

D. County Caseworker: A designated representative from the local County Department of Social/Human Services.

E. Developmental Disability: A disability that is manifested before the child reaches twenty-two years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. It includes children less than five years of age with slow or impaired development at risk of having a developmental disability.

F. Family: Defined in 27-10.5-102, C.R.S.

G. Family Foster Care Home: A family care home providing 24-hour care for a child or children. It is a facility certified by either a County Department of Social/Human Services or a child placement agency. A family foster care home, for the purposes of this waiver, shall not be a family member as defined in 27-10.5-102(15), C.R.S.

Qualifications: A qualified family foster home shall adhere to the service provision requirements of this waiver, as well as those specified and contained in CDHS Social Services Staff Manual (12 CCR 2509-6, 7.500 Resource Development).

H. Individual: Any person, such as a co-worker, neighbor, etc., who does not meet definition of a family member as described in 27-10.5-102(15). C.R.S.

Qualifications: Any individual providing a service or support must receive training commensurate with the service or support to be provided and must meet any applicable state licensing and/or certification requirements.

I. Level of Need Worksheet: A format to assess the child's level of need for services.

J. Professional: Any person, except a family member as described in 27-10.5-102(15), C.R.S. performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

Qualifications: Any person performing a professional service must possess any and all license(s) and/or certifications(s) required by the State of Colorado for the performance of that profession or professional service.

K. Programming: A plan that provides intensive, comprehensive, longitudinal instruction to help the child achieve his or her best possible functioning level.

L. Vendor: The supplier of a product or services to be purchased for a recipient of services under this waiver.

Qualifications: In order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards. In addition, such expenses over $1,000 should be chosen through a bid process. When a bid process is used and the lowest bid is not chosen, proper justification for selection of a vendor with a higher bid must be documented.

8.508.180 CHILDREN'S RIGHTS

Clients rights are defined in this section to provide the fullest possible measure of privacy, dignity and other rights to persons undergoing care and treatment in the least restrictive environment.

A. Advisement of Children's Rights: Each authorized facility shall have written policy and procedures which address and ensure the availability of each of the following rights for clients in residence.

B. All children and their guardians receiving services through the CHRP shall be advised in writing of the following rights on admission.

1. A written copy of his or her rights shall be furnished;

2. A list of such rights shall be posted prominently in the facility and translated into Spanish or any other appropriate language as needed.

3. A child may be photographed upon admission for identification and administrative purposes of the facility. No other non-medical photographs shall be taken or used without the written consent of the client's parent or legal guardian.

4. Every client has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status or disability.

5. Every child's guardian has the right to request to see the child's medical records, to see the records at reasonable times, and to be given written reasons if the request is denied.

C. Children's Rights as defined in CDHS Social Services Staff Manual, Section 7.714.50, "CHILDREN'S RIGHTS" (12 CCR 2509-8) shall also apply.

8.508.190 APPEALS

An individual who has applied for or is receiving CHRP services has a right to the appeal process established in Section 8.058 of this Manual. When an individual disagrees with a Community Centered Board (CCB) determination of developmental disability services, the dispute resolution process in the Colorado Department of Human Services, Developmental Disabilities Services rules and regulations shall apply. Section 16.320 (2 CCR 503-1).

8.509 HOME AND COMMUNITY BASED SERVICES FOR PERSONS. WITH MENTAL ILLNESS (HCBS-MI)

8.509.10 GENERAL PROVISIONS

.11 LEGAL BASIS

A. The Home and Community Based Services for PERSONS WITH MENTAL ILLNESS. (HCBS-MT) program in Colorado is authorized by a waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-MI program is also authorized under state law at 26-4-671 through 26-4-676, C.R.S. (1999). The number of recipients served in the HCBS-MI program is limited to the number of recipients authorized in the waiver.

B. All congregate facilities where any HCBS client resides must be in compliance with the "Keys Amendment" as required under Section 1616(e) of the. Social Security Act of 1935 and 45 CFR Part 1397 (October 1, 1991), by possession of a valid Assisted Living Residence license issued under 25-27-105, CR.S. (1999), and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7. No amendments or later editions are incorporated. The staff assistant of the Community Based Long Term Care Section of the Colorado Department of Health Care Policy and Financing may be contacted at 1575 Sherman Street, Denver, Colorado 80203, for a copy of 45 CFR Part 1397; or the materials may be examined at any publications depository library.

8.509.12 SERVICES PROVIDED

A. HCBS-MI services provided as an alternative to nursing facility placement include:

1. Adult day services, and

2. Alternative care facility services, including homemaker and personal care services in a residential setting, and

3. Electronic monitoring, and

4. Home, modification, and

5. Homemaker services, and

6. Non-medical transportation, and

7. Personal care; and

8. Respite care.

B. Case management is not a service, of the HCBS-MI program, but shall be provided as an administrative activity through case management agencies.

C. HCBS-MI clients are eligible, for all other Medicaid State plan benefits.

8.509.13 DEFINITIONS OF SERVICES

A. Adult Day Services shall be as defined at Section 8.491, ADULT DAY SERVICES.

B. Alternative Care Facility services means, services as defined at Section 8.495, ALTERNATIVE CARE FACILITY.

C. Electronic Monitoring services shall be as defined at Section 8.488, ELECTRONIC MONITORING.

D. Home Modification shall be as defined at Section 8.493.

E. Homemaker Services shall be as defined at Section 8.490.

F. Non-Medical Transportation shall be as defined at Section 8.494.

G. Personal Care shall be as defined at Section 8.489.

H. Respite shall be as defined at Section 8.492.

.14 GENERAL DEFINITIONS

A. Assessment shall be defined as a client evaluation according to requirements at Section 8.509.31, (B).

B. Case Management shall be defined as administrative functions performed by a case management agency according to requirements at Section 8.509.30.

C. Case Management Agency shall be defined as an agency that is certified and has a valid contract with the state to provide HCBS-MI case management.

D. Case Plan shall be defined as a systematized arrangement of information which includes the client's needs; the HCBS-MI services and all other services which will be provided, including the funding source, frequency, amount and provider of each service; and the expected outcome or purpose of such services. This case plan shall be written on a state-prescribed case plan form.

E. Categorically Eligible , shall be defined in the HCBS-MI Program, as any person who is eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical Assistance; and who retains eligibility for Medical Assistance even when the client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, or persons who are eligible for HCBS-MI as three hundred percent eligible persons, as defined at 8.509.14(S).

F. Congregate Facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

G. UNCERTIFIED CONGREGATE FACILITY shall be defined as a facility as defined above that is not certified as an alternative care facility, as defined at 8.495.11.

H. Continued Stay Review shall be defined as a re-assessment as defined at Section 8.402.60.

I. Cost Containment shall be defined as the determination that, on an individual client basis, the daily cost of providing HCBS-MI services, plus care provided under the Home Care Allowance program, does not exceed the equivalent daily cost of nursing facility care.

J. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility services reimbursed by Medicaid, within forty-five calendar days of admission to HCBS-MI. These include hospitalized clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected HCBS-MI.

K. Diverted shall be define as HCBS-MI waiver recipients who were not deinstitutionalized, as defined in this section.

L. Home and Community Based Services for Persons with Mental Illness (HCBS-MI) shall be defined as services provided in a home or community setting to clients who are eligible for Medicaid reimbursement for long term care, who would require nursing facility care without the provision of HCBS-MI, and for whom HCBS-MI services can be provided at no more than the cost of nursing facility care.

M. Intake/Screening/Referral shall be defined as the initial contact with clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long term care client assessment.

N. Level Of Care Screen shall be defined as an assessment as described in Section 8.401.

O. Non-Diversion shall be defined as a client who was certified by the Utilization Review Contractor (URC) as meeting the level of care screen and target group for the HCBS-MI program, but who did not receive HCBS-MI services for some other reason.

P. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER AGENCIES, to provide one of the services listed at Section 8.509.13. A case management agency may also become a provider if the criteria at Sections 8393.6 and 8.487 are met

Q. Reassessment shall be defined as a periodic revaluation according to the requirements at Section 8.509.32. C.

R. Department shall be defined as the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency, or another state agency operating under the authority of a memorandum of understanding with the single state Medicaid agency.

S. Three hundred percent (300%) eligible shall be defined as persons:

1) Whose income does not exceed 300% of the SSI benefit level, and

2) Who, except for the level of their income, would be eligible for an SSI payment; and

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program, or are in a nursing facility or hospitalized for thirty consecutive days.

8.509.15 ELIGIBLE PERSONS

A. HCBS-MI services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility

   Clients shall meet the eligibility criteria as specified in the Income Maintenance Staff Manual of the Colorado Department of Human Services at 9 CCR 2503-1, and the MEDICAL ASSISTANCE ELIGIBILITY section of this manual.

2. Level of Care AND Target Group.

   Clients who have been determined to meet the level of care AND target group criteria shall be certified by the URC as functionally eligible for HCBS-ML The URC shall only certify HCBS-MI eligibility for those clients:

   a. Determined to meet the target group definition for the mentally ill as defined at Section 8.400.16; and

   b. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11-15; and

   c. Who are determined to be persons with mental illness as defined by State Mental Health Services and documented by the case management agency;

   d. A length of stay shall be assigned by the URC for approved admissions, according to guidelines at Section 8.402.50.

3. Receiving Services

   a. Only clients who receive HCBS-MI services, or who have agreed to accept HCBS-MI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-MI program.

   b. Case management is not a service and shall not be used to satisfy this requirement.

   b. Desire or need for home health services or other Medicaid services that are not HCBS-MI services, as listed at Section 8.509.12, shall not satisfy this eligibility requirement.

   c. HCBS-MI clients who have received no HCBS-MI services for one month shall be discontinued from the program.

4. Institutional Status

   a. Cheats who are residents of nursing facilities or hospitals are not eligible for HCBS-MI services while residing in such institutions.

   b. A client who is already an HCBS-MI recipient and who enters a hospital may not receive HCBS-MI services while in the hospital. If the hospitalization continues

for 30 days or longer, the case manager must terminate the client from the HCBS-MI program.

c. A client who is already an HCBS-MI recipient and who enters a nursing facility may not receive HCBS-MI services while in the nursing facility;

1) The case manager must terminate the client from the HCBS-M3 program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified ULTC-100 for the nursing facility placement, as verified by telephoning the URC.

2) A client receiving HCBS-MI services who enters a nursing facility for respite care as a service under the HCBS-MI program shall not be required to obtain a nursing facility ULTC-100, and shall be continued as an HCBS-MI client in order to receive the HCBS-MI service of respite care in a nursing facility.

5. Cost-effectiveness

Only clients who can be safely served within cost containment, as defined at Section 8.509.14 (I), are eligible for the HCBS-MI program. The equivalent cost of nursing facility care is calculated by the State, according to Section 8.509.19.

8.509.16 START DATE

The start date of eligibility for HCBS-MI services shall not precede the date that all of the requirements at Section 8.509.15, have been met. The first date for which HCBS-MI services can be reimbursed shall be the LATER of any of the following:

A. Financial The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100, of Staff Manual Volume 8. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care This date is determined by the official URC stamp and the URC-assigned start date on the ULTC 100.2 form.

C. Receiving Services This date shall be determined by the date on which the client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept HCBS-MI services.

D. Institutional Status HCBS-MI eligibility cannot precede the date of discharge from the hospital or nursing facility.

8.509.17 CLIENT PAYMENT OBLIGATION - POST ELIGIBILITY TREATMENT OF INCOME (PETI)

When a client has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, of Staff Manual Volume 8, the State may reduce Medicaid payment for Alternative Care Facility services according to the procedures at Section 8.509.31, E, of Staff Manual Volume 8.

8.509.18 STATE PRIOR AUTHORIZATION OF SERVICES

A. Upon receipt of the prior authorization request (PAR), as described at Section 8.509.31, G, of Staff Manual Volume 8, the state or its agent shall review the PAR to determine whether it is in

compliance with all applicable regulations, and whether services requested are consistent with the client's documented medical condition and functional capacity, and are reasonable in amount, frequency, and duration. Within ten (10) working days the State or its agent shall:

1. Approve the PAR and forward signed copies of the prior authorization form to the case management agency, when all requirements are met;

2. Return the PAR to the case management agency, whenever the PAR is incomplete, illegible, unclear, or incorrect; or if services requested are not adequately justified;

3. Disapprove the PAR when all requirements are not met Services shall be disapproved that are duplicative of other services that the client is receiving or services for which the client is receiving funds to purchase Services shall also be disapproved if all services, regardless of funding source, total more than twenty-four hours per day care.

B. When services are disapproved, in whole or in part the Department or its agent shall notify the case management agency. The case management agency shall notify the client of the adverse action and the appeal rights on a state-prescribed form, according to Section 8.057, et seq. Staff Manual Volume 8.

C. Revisions received by the Department or its agent six months or more after the end date shall always be disapproved.

D. Approval of the PAR by the Department or its agent shall authorize providers of services under the case plan to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon the client's financial eligibility for long term care medical assistance (Medicaid) on the dates of service; and upon providers' use of correct billing procedures.

8.509.19 STATE CALCULATION OF COST-CONTAINMENT AMOUNT

A. The State shall annually compute the equivalent monthly cost of nursing facility care ACCORDING TO SECTION 8.485.100.

B. LIMITATIONS ON PAYMENT TO FAMILY

1. In no case shall any person be reimbursed to provide HCBS-MI services to his or her spouse.

2. Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-MI program subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption or common law.

3. The family member shall meet all requirements for employment by a certified personal care agency, and shall be employed and supervised by the personal care agency.

4. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

   a. The total number of Medicaid personal care units for a member of the client’s family shall not exceed the equivalent of 444 personal care units per annual certification for HCBS-MI.

   b. The maximum shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker’s

compensation, FICA, cost of training and supervision and all other administrative costs.

c. The maximum number of personal care units per annual certification for HCBS-MI shall be 444 units. Family members must average at least 1.2164 hours of care per day (as indicated on the client's care plan) in order to receive the maximum reimbursement.

d. If the certification period for HCBS-MI is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the client is receiving care by the average units per day for a full year (444/365=1.2164).

5. If two or more HCBS-MI clients reside in the same household, family members may be reimbursed up to the maximum for each client if the services are not duplicative and are appropriate to meet the client's needs.

6. When HCBS-MI funds are utilized for reimbursement of personal care services provided by the client's family, the home care allowance cannot be used to reimburse the family.

7. Services other than personal care shall not be reimbursed with the HCBS-MI funds when provided by the client's family.

8. Services other than personal care shall not be reimbursed with the HCBS-MI funds when provided by the client's family.

C. CLIENT RIGHTS

1. The case manager shall inform clients eligible for HCBS-MI in writing, of their right to choose between HCBS-MI services and nursing facility care.

2. The case manager shall offer clients eligible for HCBS-MI, the free choice of any and all available and qualified providers of appropriate services.

8.509.20 CASE MANAGEMENT AGENCIES

.21 CERTIFICATION

A. Case management agencies shall be certified, monitored and periodically recertified according to current Rules and Regulations For The Colorado Public Mental Health System.

B. Case management agencies must have provider agreements with the Department that are specific to the HCBS-MI program.

.22 REIMBURSEMENT

Case management agencies shall be reimbursed for case management activities according to current procedures as approved by the State Mental Health Authority.

8.509.30 CASE MANAGEMENT FUNCTIONS

.31 NEW HCBS-MI CASES

A. INTAKE/SCREENING/REFERRAL

1. Case management agency staff shall complete a State-prescribed Intake form for each potential HCBS-MI applicant. The Intake form must be completed before an assessment is initiated. The Intake form may also be used as a preliminary case plan form when signed by the applicant for purposes of establishing a start date. Additionally, at intake, clients shall be offered an opportunity to identify a third party to receive client notices. This information shall be included on the intake form. This designee shall be sent copies of all notices sent to clients.

2. Case management agency staff shall verify the individual's current financial eligibility status, or refer the client to the county department of social services of the client's county of residence for application. This verification shall include whether the applicant is in a category of assistance that includes financial eligibility for long term care.

3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a comprehensive uniform long term care client assessment (ULTC-100), and shall explain the reasons for the decision on the Intake form. The client shall be informed of the right to request an assessment if the client disagrees with the case manager's decision.

4. If the case management agency staff has determined that a comprehensive uniform long term care client assessment (ULTC-100) is needed, or if the client requests an assessment, a case manager shall be assigned to schedule the assessment

B. ASSESSMENT

1. The URC/SEP case manager shall complete the Uniform Long Term Care Client Assessment Instrument (ULTC 1(0.2) in accordance with instructions provided by the State.

2. The URC/SEP case manager shall begin and complete the assessment within ten (10) days of notification of client's need for assessment.

3. The URC/SEP case manager shall complete the following activities for a comprehensive client assessment:

    a. Obtain all required information from the client's medical provider including information required for target group determination;

    b. Determine the client's functional capacity during a face-to-face interview, preferably with the observation of the client in his or her residential setting;

    c. Determine the ability and appropriateness of the client's caregiver, family, and other collateral, to provide the client assistance in activities of daily living;

    d. Determine the client's service needs, including the client's need for services not provided under HCBS-MI;

4.

    e. If the client is a resident of a nursing facility, determine the feasibility of deinstitutionalization;

    f. Review service options based on the client's needs, the potential funding

sources, and the availability of resources;

g. Explore the client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with state rules;

h. View and document the current Assisted Living Residence license, if the client lives, or plans to live, in a congregate facility as defined at Section 8.509.14, Staff Manual Volume 8, in order to assure compliance with the regulation at 8.509.11, B, Staff Manual Volume 8;

i. Determine and document client preferences in program selection;

j. Complete documentation on the ULTC 100.2 form.

k. To de-institutionalize a client who is in a nursing facility under payment by Medicaid, and with a current ULTC 100.2 already certified by the URC/SEP agency for the nursing facility level of ULTC 100 completion date is older than six (6) months, the URC/SEP case manager shall complete a new ULTC 100.2 and determine if the client continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a client leaves a nursing facility, and no one has notified the URC/SEP agency of the client's intent to apply for HCBS-MI, the case manager must obtain a new ULTC 100.2 and the client shall be treated as an applicant from the community rather than as a de-institutionalized client.

l. It is the URC/SEP case manager's responsibility to assess the behaviors of the client and assure that community placement is appropriate.

C. HCBS-MI DENIALS

1. If a client is determined, at any point in the assessment process, to be ineligible for HCBS-MI according to any of the requirements at Section 8.509.15, Staff Manual Volume 8, the case manager shall refer the client or the client's designated representative to other appropriate services. Clients who are denied HCBS-MI services shall be notified of denials and appeal rights as follows:

   a. Financial Eligibility

   The income maintenance technician at the county department of social services shall notify the applicant of denial for reasons of financial eligibility, and shall inform the applicant of appeal rights in accordance with Sections 3.840 and 3.850 of the Colorado Department of Human Services' Staff Manual Volume III at 9 CCR 2503-1. The case manager shall not attend the appeal bearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the state.

   b. Level of Care AND Target Group

   The URC shall notify the applicant of denial for reasons related to determination of level of care AND target group eligibility and shall inform the applicant of appeal rights in accordance with Section 8.059.12, of Staff Manual Volume 8. The case manager shall not make judgments as to eligibility regarding level of care or target group, and shall refer all applicants who request a URC review to

the URC, independently of any action that may be taken by the case manager in regard to other eligibility requirements, in accordance with the rest of this section. The case manager shall not attend the appeal hearing for a denial based on level of care or target group determination, unless subpoenaed, or unless requested by the state.

c. Receiving Services

The case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determine that the applicant does not meet the HCBS-MI eligibility requirements at Section 8.509.15, of Staff Manual Volume 8, and shall inform the applicant of appeal rights in accordance with Section 8.057, et. seq., of Staff Manual Volume 8. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

d. Institutional Status

The case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determine that the applicant does not meet the eligibility requirement 2 Section 8.509.15, of Staff Manual Volume 8, and shall inform the applicant of appeal rights in accordance wit Section 8.057, et. seq., of Staff Manual Volume 8. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

e. Cost-effectiveness

The case manager shall notify the applicant of denial, on State-prescribed form, when the case manager determine that the applicant does not meet the eligibility requirement 8.509.15, of Staff Manual Volume 8, and shall inform the applicant of appeal rights in accordance with Section 8.05, et.seq., of Staff Manual Volume 8.The case manager shall also attend the appeal hearing to defend this denial action. If the applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the applicant, and the competency of the applicant to choose to live in an unsafe situation. If the case manager determines that the applicant will be unsafe with the amount of services available, and is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-MI eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the client's physician attesting to the client's mental competency status, and all other available information which will support the determination that the client is unsafe and incompetent to make a decision to live in an unsafe situation; and, which will satisfy the burden of proof required of file case manager making the denial. Denials and appeals for reasons of cost-effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the URC in regard to level of care and target group determination.

f. Waiver Cap

The case manager shall notify the applicant of denial, on a State-prescribed form, when the waiver cap limiting the number of clients who may be served under the terms of the approved waiver has been reached.

D. CASE PLANNING

1. Case planning shall include, but not be limited to, the following tasks:

    a. The identification and documentation of case plan goals and client choices;

    b. The identification and documentation of all services needed, including type of service, specific functions to be performed, frequency and amount of service, type of provider, finding source, and services needed but not available;

    c. Documentation of the client's choice of HCBS-MI services, nursing home placement, or other services, including a signed statement of choice from the client;

    d. Documentation that the client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the client understands his/her right to change providers;

    e. The formalization of the case plan agreement on a State-prescribed case plan form, including appropriate signatures;

    f. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the client regarding service provision;

    g. Referral to community resources as needed and development of resources for individual clients if a resource is not available within the client's community;

    h. The explanation of complaint procedures to the client.

2. The case manager shall meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

E. CALCULATION OF CLIENT PAYMENT (PETI)

1. The case manager shall calculate the client payment (PETI) for 300% eligible HCBS-MI clients according to the following procedures:

    a. For 300% eligible HCBS-MI clients who are not Alternative Care Facility clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required to be completed.

    b. For 300% eligible clients who are Alternative Care Facility clients, the case manager shall complete a State-prescribed form which calculates the client payment according to the following procedures:

        1) An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the client's gross income to be used as the client maintenance allowance, from which the state-prescribed Alternative Care Facility room and board amount shall be paid: and

2) For an individual with financial responsibility for only a spouse, an amount equal to the state Aid to the Needy and Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the client's gross income: or

3) For an individual with financial responsibility for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Aid to Families with Dependent Children (AFDC) grant level less any income of the spouse and or dependents (excluding pan-time employment earnings of dependent children as defined at Section 8.112.3(F) of Staff Manual Volume 8). shall be deducted from the client's gross income; and

4) Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare. Medicaid. or other third party shall be deducted from the client's gross income as follows:

a) Health insurance premiums if health insurance coverage is documented in the eligibility system and the MMIS: deductible or co-insurance charges: and

b) Necessary dental care not to exceed amounts equal to actual expenses incurred: and

c) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred: and

d) Medications, with the following limitations:

(1) The need for such medications shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.

(2) Medications which may be purchased with the client’s Medical Identification Card shall not be allowed as deductions.

(3) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

(4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.

(5) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.

e) Other necessary medical or remedial care shall be deducted

from the client's gross income, with the following limitations:

(1) The need for such care shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and, shall be renewed at least annually or whenever there is a change.

(2) Any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.

f) Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

g) When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

5) Any remaining income-shall be applied to the cost of the Alternative Care Facility services, as defined at Section 8.495, and shall be paid by the client directly to the facility; and

6) If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the client's income, the remaining income shall be kept by the client and may be used as additional personal needs or for any other use that the client desires. except that the Alternative Care Facility shall not charge more than the Medicaid rate for Alternative Care Facility services.

2. Case managers shall inform HCBS-MI Alternative Care Facility clients of their client payment obligation on a form prescribed by the state at the time of the first assessment visit by the end of each plan period; or within ten (10) working days whenever there is a significant change in the cheat payment amount Significant change is defined as fifty dollars (S50) or more. Copies of client payment forms shall be kept in the client files at the case management agency, and shall not be mailed to the State or its agent, except as required for a prior authorization request, according to Section 8.509.31.G, of Staff Manual Volume 8. or if requested by the state for monitoring purposes.

F. COST CONTAINMENT

The case manager shall determine whether the person can be served at or under the cost ceiling for long term care services for an individual recipient by using a state-prescribed Prior Authorization Request (PAR) form 10:

1. Determine the maximum authorized costs for all HCBS-MI services for the period of time covered by the case plan and compute the average cost per day by dividing by the number of days in we case plan period; and

2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:

    a. Enter (in the designated space on the PAR form) the average monthly cost of nursing facility care as calculated by the State according to Section 8.485.100. of Staff Manual Volume 8: and

    b. Subtract from that amount the client's gross monthly income: and

    c. Subtract from that amount the client's Home Care Allowance grant amount, if any: and

    d. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount which cannot be exceeded for the cost of HCBS services.

3. An individual client whose service needs exceed the amount allowed under the client's individual cost containment amount may choose to purchase additional services with personal income, but no client shall be required to do so.

G. PRIOR AUTHORIZATION REQUESTS

1. The case manager shall submit prior authorization requests (PARs) for all HCBS-MI services to the state or its agent in a timely manner.

2. Every PAR shall include the Long Term Care Plan form; the Prior Approval Request form; the Uniform Long Term Care Client Assessment (ULTC-100) form; and written documentation, from the income maintenance technician or the eligibility system, of the client's current monthly income. All units of service requested on the Prior Approval Request form must be listed on the Long Term Care Plan form. If a range of units is estimated on the Long Term Care plan, the number of units at the higher end of the range may be requested on the Prior Approval Request form. "PRN" services must be given a numerical estimate on the Long Term Care plan.

3. If a PAR is for a new admission, or a re-admission, the Intake form shall be included with the PAR.

4. If a PAR includes a request for home modification services, the PAR shall also include all documentation listed at Section 8.493, HOME MODIFICATION, of Staff Manual Volume 8.

5. If a PAR is for an Alternative Care Facility client who is 300% eligible, the most recent state-prescribed Client Payment form shall be included in the PAR. All medical and remedial care requested as deductions on the Client Payment form must be listed on the LONG TERM Case Plan form.

6. The start date on the prior authorization request form shall never precede the start date of eligibility for HCBS-MI services, according to Section 8.509.16, START DATE, of Staff Manual Volume 8.

7. The PAR shall not cover a period of time longer than the length of stay assigned by the URC.

8. A PAR does not have to be submitted for a non-diversion, as defined at 8.509.14, M.

9. If a PAR is returned to the case management agency for corrections, the corrected PAR must be returned to the State or its agent within 30 calendar days after the case management agency receives the "return to provider" letter.

H. CASE MANAGEMENT AGENCY RESPONSIBILITY

1. The case management agency shall be financially responsible for any services which it authorized to be provided to the client, or which continue to be rendered by a provider due to the case management agency's failure to timely notify the provider that the client was no longer eligible for services, which did not receive approval by the state or its agent.

8.509.32 ONGOING HCBS-MI CASES

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The case manager shall monitor the services that are being provided, the appropriateness and effectiveness of services provided, the amount of care, the timeliness of service delivery, client satisfaction, the safety of the client, and shall take corrective actions as needed. Monitoring contacts must occur and be documented at least once every three months, or more frequently as determined by the client's needs.

2. The case manager shall contact each client on a face-to-face basis at least once every three months, or more frequently as determined by the client's needs.

3. The case manager shall refer the client for mental health services taking into account client choice. The case manager shall coordinate case management activities for those clients who are receiving mental health services from the Mental Health Assessment and Service Agencies (MHASAs).

4. On-going case management shall include, but not be limited to the following tasks:

a. Review of the client's case plan and service agreements;

b. Contact with the client concerning whether services are being delivered according to the plan; and the client's satisfaction with services provided;

c. Contact with service providers concerning service delivery, coordination, effectiveness, and appropriateness;

d. Contact with appropriate parties in the event any issues or complaints have been presented by the client or others;

e. Conflict resolution and/or crisis intervention, as needed;

f. Informal assessment of changes in client functioning, service effectiveness, service

appropriateness, and service cost-effectiveness;

g. Notification of appropriate enforcement agencies, as needed; and

h. Referral to community resources, and arrangement for non-HCBS-MI services, as needed.

4. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or misutilization of any public assistance or Medicaid benefit. The case manager shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with the Colorado Department of Human Services' Staff Manual Volume 3, Section 3.810.

B. REVISIONS

1. SERVICES ADDED TO THE CASE PLAN

a. Whenever a change in the case plan results in an increase or change in the services to be provided, the case manager shall submit a revised prior authorization request (PAR) to the state or its agent.

1) The revision PAR shall include the revised Long Term Care plan form and the revised Prior Authorization Request form.

2) The revised case plan form shall list the services being revised and shall state the reason for the revision. Services on the revised case plan form, plus all services on the original case plan form, must be entered on the revised Prior Authorization Request form, for purposes of reimbursement.

3) The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.

b. If a revised PAR includes a new request for home modification services, the revised PAR shall also include all documentation listed at Section 8.493, of Staff Manual Volume 8.

2. SERVICES DECREASED ON THE CASE PLAN

a. A revised PAR does not need to be submitted if services on the case plan are decreased or not used, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness

b. If services are decreased without the client's agreement according to Section 8.057.5, of Staff Manual Volume 8, the case manager shall notify the client of the adverse action and of appeal rights, according to Section 8.057, et. seq., of Staff Manual Volume 8.

C. REASSESSMENT

1. The case manager shall complete a reassessment of each HCBS-MI client before the end of the length of stay assigned by the URC at the last level of care determination. The case manager shall initiate a reassessment more frequently when warranted by significant changes that may affect HCBS-MI eligibility.

2. The case manager shall complete the reassessment, utilizing the Uniform Long Term Care Client Assessment Instrument (ULTC 100.2).

3. Reassessment shall include, but not be limited to, the following activities:

    a. Verify continuing Medicaid eligibility, including verification of an aid category that includes eligibility for long term care benefits;

    b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;

    c. Evaluate continuing need for the HCBS-MI program, and clearly document reasons for continuing HCBS; or terminate the client's eligibility according to Section 8.509.32, E, of Staff Manual Volume 8;

    d. Ensure that all information needed from the medical provider for the URC level of care review is included on the ULTC 100.2 form;

    e. Reassess the client's functional status, according to the procedures in Section 8.509.31,B, of Staff Manual Volume 8;

    f. Review the case plan, including verification of whether services have been delivered according to the case plan, and write a new case plan, according to procedures at Section 8.509.31, D, of Staff Manual Volume 8;

    g. Refer the client to community resources as needed;

    h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31,G, of Staff Manual Volume 8. For clients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ULTC 100.2. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the client and sent to the URC or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the URC or the Division Office of Administrative Courts to the client; or (c) a copy of the notice of a scheduled court date.

        Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed, and shall not be accepted as a substitute for the approved ULTC 100.2. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

D. TRANSFER PROCEDURES

When clients move, cases shall be transferred according to the current statewide Mental Health Services Continuity of Care Policy.

E. TERMINATION

1. Clients shall be terminated from the HCBS-MI program whenever they no longer meet one or more of the eligibility requirements at Section 8.509.15, of Staff Manual Volume 8. Clients shall also be terminated from the program if they die, move out of state or voluntarily withdraw from the program.

2. Clients who are terminated from HCBS-MI because they no longer meet one or more of the eligibility requirements at Section 8.509.15, of Staff Manual Volume 8, shall be notified of the termination and their appeal rights as follows:

    a. Financial Eligibility

        Procedures at Section 8.509.31, C, of Staff Manual Volume 8, shall be followed for terminations for this reason.

    b. Level of Care AND Target Group

        Procedures at Section 8.50931, C, of Staff Manual Volume 8, shall be followed for terminations for this reason.

    c. Receiving Services

        Procedures at Section 8.509.31, C, of Staff Manual Volume 8, shall be followed for terminations for this reason

    d. Institutional Status

        Procedures at Section 8.509.31, C, of Staff Manual Volume 8, shall be followed for terminations for this reason. In the case of termination for extended hospitalization, the case manager shall send the termination notice on the thirtieth day of hospitalization. The termination shall he effective at the end of the advance notice period. If the client returns home before the end of the advance notice period, the termination shall be rescinded.

    e. Cost-effectiveness

        Procedures at Section 8.509.31(C) of Staff Manual Volume 8, shall be followed for terminations for this reason.

3. When clients are terminated from HCBS-MI for reasons not related to me eligibility requirements at Section 8.509.31(C) of Staff Manual Volume 8, the case manager shall follow the procedures below:

    a. Death

        Clients who die shall be terminated from the HCBS-MI program, effective upon the day after the date of death.

    b. Moved out of State

        Clients who move out of Colorado shall be terminated from the HCBS-MI program, effective upon the day after the date of the move. The case manager shall send the client a state-prescribed Advisement Letter advising the client that the case has been closed. Clients who leave the stale on a temporary basis, with intent to return to Colorado, according to the Income Maintenance Staff Manual Section 1140.2, shall not be terminated from the HCBS-MI program unless one or

more of the other eligibility criteria, as specified at Section 8.509.15 of Staff Manual Volume 8 is no longer met.

c. Voluntary Withdrawal from the Program

Clients who voluntarily withdraw from the HCBS-MI program shall be terminated from the program, effective upon the day after the date on which the client either requests in writing to withdraw from the program, or the date on which the client enters a nursing facility. The case manager shall send the client a state-prescribed Advisement Letter advising the client that the case has been closed.

4. The case manager shall provide appropriate referrals to other community resources, as needed, upon termination.

5. The case manager shall immediately notify all providers on the case plan of any terminations.

6. If a case is terminated before an approved PAR has expired, the case manager shall submit, to the state or its agent, a copy of the current prior authorization request form, on which the end date is adjusted (and highlighted in some manner on the form); and the reason for termination shall be written on the form.

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATION

In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

1. The case manager shall inform the income maintenance technician of any and all changes in the client's participation in HCBS-MI, and shall provide the technician with copies of the first page of all URC-approved ULTC-100 forms.

2. The case manager shall inform all Alternative Care Facility clients of their obligation to pay the full and current state-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

3. If the client has an open service case file at the county department of social services, the case manager shall keep the client's caseworker informed of the client's status and shall participate in mutual staffing of the client's case.

4. The case manager shall inform the client's physician of any significant changes in the client's condition or needs.

5. Within five (5) working days of receipt, from the State or it; agent, of the approved Prior Authorization Request form, the case manager shall provide copies to all the HCBS-MI providers in the case plan.

6. The case manager shall notify the URC, on a form prescribed by the state of the outcome of all non-diversions, as defined at Section 8.509.14, of Staff Manual Volume 8.

7. The case manager shall report to the Colorado Department of Public Health and Environment any congregate facility which is not licensed.

8. The case management agency shall notify the state of any client appeals which are initiated as a result of denials or terminations made by the case management agency.

B. CASE RECORDING/DOCUMENTATION

1. The case management agency shall maintain records on every individual for whom intake was conducted, including a copy of the intake form. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the case management agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.

2. The case record shall include:

    a. Identifying information, including the state identification (Medicaid) number, and

    b. All state-required forms; and

    c. Documentation of all case management activity required by these regulations.

3. Case management documentation shall meet all the following standards:

    a. A separate case record shall be maintained for each client receiving services in the Home and Community Based Services for Persons with Mental Illness Program.

    b. Documentation shall be legible;

    c. Entries shall be written at the time of the activity or shortly thereafter,

    d. Entries shall be dated according to the date of the activity, including the year;

    e. Entries shall be made in permanent ink;

    f. The client shall be identified on every page;

    g. The person making each entry shall be identified;

    h. Entries shall be concise, but shall include all pertinent information;

    i. All information regarding a client shall be kept together for easy access and review by case managers, supervisors, program monitors and auditors;

    j. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact, or is a judgment or conclusion on the part of anyone;

    k. All persons and agencies referenced in the documentation shall be identified by name and by relationship to the client;

    l. All forms prescribed by the State shall be filled out by the case manager to be complete, correct and accurate.

4. All records shall be kept for the period of time specified in the case management agency contract, and shall be made available to the state as specified in the contract.

8.509.40 HCBS-MI PROVIDERS

A. Any provider agency with a valid contract to provide HCBS-EBD services, according to Section 8.487, of Staff Manual Volume 8, shall be deemed certified to provide the same services to HCBS-MI

clients.

8.515.00 HOME AND COMMUNITY BASED SERVICES FOR PEOPLE WITH BRAIN INJURY (HCBS-BI)

8.515.11 LEGAL BASIS

The Home and Community Based Services for people with Brain Injury (HCBS-BI) program in Colorado is authorized by a waiver of the amount, duration, and scope of service requirements contained in Section 1902 (a)(10)(B) of the Social Security Act. The rules governing the HCBS-BI program will be in effect after approval is received from the United States Department of Health and Human Services, under Section 1915 (c) of the Social Security Act. The HCBS-BI program is authorized under State law at 26-4-681 et seq., C.R.S. to 26-4-685, as amended.

8.515.13 DEFINITIONS OF SERVICES PROVIDED

HCBS-BI services are provided as an alternative to hospital and inpatient rehabilitation facility placement and include:

A. Adult Day Services means services as defined at Section 8.515.70, ADULT DAY SERVICES.

B. Assistive Equipment means devices, equipment and services as defined in Section 8.515.50, ASSISTIVE AND SPECIAL MEDICAL EQUIPMENT.

C. Behavioral Programming means, services as defined in Section 8.516.40. BEHAVIORAL PROGRAMMING.

D. Case Management means services as defined in Section 8.515.30. CASE MANAGEMENT.

E. Counseling and Training Including Substance Abuse Treatment and Family Counseling means services as defined in Section 8.516.60. COUNSELING.

F. Day Treatment means services as defined in Section 8.515.80. DAY TREATMENT.

G. Environmental Modification means services as defined in Section 8.5.6.00. ENVIRONMENTAL MODIFICATION.

H. Independent Living Skills Training means services as defined in Section 8.516.20, INDEPENDENT LIVING SKILLS. TRAINING.

I. Non-medical Transportation means services as defined at Section 8.524. NON-MEDICAL TRANSPORTATION.

J. Personal Care means, services, as defined at Section 8.515.60, PERSONAL CARE SERVICES.

K. Respite Care means services as defined at Section 8.515.90. RESPITE CARE.

L. Supported Living means services as defined at Section 8.514.14, Q in GENERAL DEFINITIONS-SUPPORTED LIVING.

M. Transitional Living means services as defined in Section 8.516:40. TRANSITIONAL LIVING.

8.515.14 GENERAL DEFINITIONS

A. Agency means any public or private entity that operates in a for-profit or nonprofit capacity, and has a

defined administrative and organizational structure. Any sub-unit of such agency that is not geographically close enough to the agency to share administration and supervision on a frequent and adequate basis shall be considered a separate agency for purposes of certification and contracts.

B. Assessment means a comprehensive face-to-face interview with the client and appropriate collaterals (such as family members, friends and or caregivers) and an evaluation by the hospital discharge planner or case manager, with supported diagnostic information from the client's physician. and other rehabilitation therapists to determine the client's level of functional ability, service needs, potential to benefit from further rehabilitative intervention, available community resources, and potential funding sources.

C. Brain Injury is defined as an injury to the brain of traumatic or acquired origin, which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature, and includes the following ICD-9-CM codes:

- 310-310.9 specific non-psychotic mental disorders due to organic brain syndrome ;
- 348.1 Anoxic brain damage;
- 431.0 Intracerebral hemorrhage;
- 436-438 cerebrovascular disease, acute, but ill-defined, other and ill-defined, and late effects of disease;
- 800.00-800.9 fracture of vault of skull;
- 801-801.9 fracture of base of skull;
- 803-803.9 other and unqualified skull fractures;
- 804-804.99 multiple fracture involving skull or face with other bones;
- 850-850.9 concussion;
- 851-854.19 intracranial injury and hemorrhage following injury;
- 904.0-907.0 late effects of fracture of skull and face bones and late effect of intracranial injury without mention of skull fractures (if admission to acute hospitalization is for a different primary diagnosis);
- 349.82 toxic encephalopathy ;
- 198.3 -secondary malignant neoplasm of brain, spinal cord and other pans of nervous system.

Copies of the International Classification of Diseases Manual - Clinical Modification are available from the Brain Injury Program Coordinator. Office of Public and Private Initiatives of the Department of Health Care Policy and Financing at 1575 Sherman St. Denver. CO 80203. or may be examined at any State Publications Depository Library. Later amendments or additions are not included in this rule.

D. Case Management Agency means an agency which is certified and has a valid contract with the department to provide HCBS-BI case management.

E. Care Plan means a systematized arrangement of information which includes the client's needs: the

HCBS-BI services and all other services which will be provided, including the funding source, frequency, amount and provider of each service: and the expected outcome or purpose of such services. This care plan shall be written on a state-prescribed care plan form and upon monthly reassessment of the client, shall be revised as dictated by the client's progress.

F. Categorically Eligible as it is used in relation to the HCBS-BI Program, means any person who is eligible for medical assistance or for a combination of financial and medical assistance: and who retains eligibility for medical assistance even when he or she is not a resident of a nursing facility or hospital or is not a recipient of an HCBS program. Persons who are eligible for financial assistance, but not for medical assistance, are not included in the definition of categorically eligible, as the term is used in relation to the HCBS-BI program. The term also excludes persons who are eligible for HCBS-BI as three hundred percent eligible persons, as defined in this section.

G. Congregate Facility means a residential facility that Provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services, and social care but do not require regular twenty four hour medical or nursing care.

H. Continued Stay Review means a re-evaluation by the URC/SEP agency to determine the continued functional necessity of that level of care. Continued stay reviews will be performed every six months, for the 1st year, and annually or when the URC/SEP case manager determines that the client no longer meets the level of care necessary for continued program eligibility.

I. Cost Ceiling means the determination that, on an individual client basis, the daily cost of providing HCBS-BI services does not exceed the equivalent daily cost of hospital facility care.

J. Department means the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

K. Home and Community Based Services for persons with Brain Injury (HCBS-BI) means service provided in a home or community based setting to individuals who are eligible for Medicaid for one of two levels of care:

1. Post acute care/long term care, for clients requiring hospital level of care without the provision of intensive HCBS-BI services that can be provided at no more than the cost of hospital care.

2. Supportive Living Program services for those requiring specialized nursing facility level of care without the provision of HCBS-BI services that can be provided at no more than the individual's calculated cost if institutionalized.

L. Independent Living Skills training means skills and therapies as defined at 26-4-683 (5), C.R.S.

M. Community Services may be provided in the client's residence, in the community or in a group living situation.

N. Intake/screening/referral for the HCBS-BI program means the initial contact with individuals by the URC/SEP case manager. This process shall include, but not be limited to, the following areas; an individual's

O. Provider Agency means an agency, as defined in this section, which is certified by the Department to provide one of the services listed at Section 8.393.61 DEFINITIONS OF SERVICES, with the exception of case management provided by a single entry point agency, which is considered an administrative function rather than a service. However, a single entry point agency may become a service provider if they meet all criteria at 8.393.61, PROVIDER OF DIRECT SERVICES.

P. Reassessment means a comprehensive face-to-face interview conducted with the client and appropriate collateral contacts, which includes an evaluation by the case manager, collection of supporting diagnostic information from the client's physician to determine the client's level of functioning, service needs, available resources, and potential funding resources.

Q. Supportive Living Care Campus means a residential campus that provides supported supportive living services.

R. Single Entry Point (SEP) entry point agency means an organization as described at Section 8.390.1,P, LONG TERM CARE SINGLE ENTRY POINT SYSTEM.

S. Supportive Living means assistance or support provided by a 24 hour residential facility or Supported Living Care Campus asked at 26-4-638(8), C.R.S. (2003).

T. Three hundred percent (300%) eligible means persons whose income does not exceed 300% of the SSI benefit level; who, except for the level of their income, would be eligible for an SSI payment; and who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program, or are in a nursing facility or hospitalized for thirty consecutive days.

8.515.15 ELIGIBLE PERSONS

A. HCBS-BI services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility

Individuals must meet the financial eligibility criteria as specified in Section 8.110.5 MEDICAL ASSISTANCE ELIGIBILITY. The parental income of non-emancipated children between the ages of 16-18 will be counted in the determination of that child's eligibility for medical assistance.

2. Level of Care

Individuals 16-64 years of age who have a diagnosis of Brain Injury and who continue to require one of the following two levels of care shall be eligible:

a. Hospital level of care as evidenced by all of the following:

i. The client is currently receiving inpatient hospital care in an acute medical facility or rehabilitation facility and should be no more than six-months post Brain Injury.

ii. The client continues to require goal-oriented therapy with medical management by a physician with special training or experience in the field of Brain Injury rehabilitation.

iii. The client continues to require and benefit from medically necessary specialized rehabilitation services including at least two of the following: neuropsychological intervention, social work, life skills training, behavioral management, counseling, Respite Care, Personal Care, Non-Medical Transportation, adult day care, Day Treatment, Transitional Living, Assistive Equipment, Environmental Modification, speech therapy, physical therapy, occupational therapy, vocational rehabilitation, recreational therapy or home health services.

iv. The client cannot be therapeutically managed in the home without significant

supervision and structure, specialized therapy and support services.

v. The client has a prognosis for continued functional improvement.

b. Specialized nursing facility level of care provided by a 24-hour Supportive Care facility or Campus as evidenced when:

i. The client continues to require and benefit from medically necessary specialized supportive services including at least two of the following: interpersonal and social life skills training, behavioral management and cognitive supports, counseling, improved household management, Personal Care, Non-Medical Transportation, adult day care, Day Treatment, Assistive Equipment, Environmental Modification, speech therapy, physical therapy, occupational therapy, , recreational therapy, medical management or home health services.

ii. The client requires long-term specialized daily assistance that cannot be provided in a nursing facility.

iii. The client's independence can be maximized in the community by provision of 24-hour supervision, structure and supportive services provided in a community-based facility by staff with specialized behavioral and cognitive management training.

iv. The client has maximized his or her acute and rehabilitation potential.

3. Receiving HCBS-BI Services

Once all other eligibility criteria have been established, only persons who actually receive at least one HCBS-BI service, or who have agreed to accept HCBS-BI services are eligible for the HCBS-BI program. Desire or need for home health services or other Medicaid services that are not HCBS-BI services, as listed at Section 8.515.13, will not satisfy this eligibility requirement. Case management is provided as an administrative function of the waiver program and is not a service of the waiver program; therefore, it cannot be used to satisfy this eligibility requirement. HCBS-BI recipients who have received no HCBS-BI services for one month will be discontinued from the program.

4. Institutional Status

a. Persons who are current residents of nursing facilities or hospitals are not eligible to receive HCBS-BI services.

b. An individual who is already an HCBS-BI recipient and who enters a hospital for treatment may not receive HCBS-BI service while in the hospital; and if the hospitalization continues for 30 days or longer, the URC/SEP case manager must terminate the client from the HCBS-BI program.

c. An individual who is already an HCBS-BI recipient aid who enters a nursing facility may not receive HCBS-BI service while in the nursing facility; and the URC/SEP case manager must terminate the client from the HCBS-BI program if Medicaid pays for all or part of the nursing facility care. However, a recipient of HCBS-BI services who enters a nursing facility for respite care as a service under the HCBS-BI program shall not be required to obtain a nursing facility ULTC 100.2, but shall be continued as an HCBS-BI waiver participant and recipient of respite care in a nursing facility.

5. Cost Ceiling

Only persons who can be safely served within the cost ceiling, as defined in Section 8.515.19, are eligible for the HCBS-BI program. The equivalent cost of hospital care is calculated by the Department according to Section 8.515.19, DEPARTMENT CALCULATION OF COST CONTAINMENT AMOUNT.

8.515.16 START DATE FOR SERVICES

The period of eligibility for services will begin the day the Utilization Review Contractor certifies medical eligibility and will remain in effect as long as there is a current, valid certificate of medical necessity.

8.515.17 CLIENT PAYMENT OBLIGATION-POST ELIGIBILITY TREATMENT OF INCOME (PETI)

The case manager shall calculate the client PETI payment for 300% eligible HCBS-BI clients according to the following procedures:

A. For 300% eligible HCBS-B1 clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required to be completed.

B. An individual client whose service needs exceed the amount allowed under the client's individual cost containment amount may choose to purchase additional services with personal income, but no client shall be required to do so.

C. For clients who are temporary residents of a transitional living program, deductions of up to $400/month are allowed as client contributions toward deferring the room and board expense of transitional living which is not a covered benefit of the Medicaid program.

8.515.18 PRIOR AUTHORIZATION OF SERVICES

This section defines the process of prior authorization for service. For further information on responsibilities for submission of prior authorization for services, please refer to 8.515.30.1.

A. Upon receipt of the prior authorization request (PAR) as described at Section 8.515.30, I. PRIOR AUTHORIZATION REQUESTS, the Department or its agent shall review the PAR to determine whether it is in compliance with all applicable regulations, whether services requested are consistent with the client's documented medical condition and functional capacity, and whether services are reasonable in amount, frequency and duration. The Department or its agent shall:

1. Approve the PAR and forward signed copies of the Prior Authorization form to the case management agency or hospital discharge planner, when requirements are met;

2. Return the PAR to the case management agency, whenever the PAR is incomplete, illegible, unclear or incorrect; or if services requested are not adequately justified;

3. Disapprove the PAR when any of the requirements are not met. Services shall be disapproved that are duplicative of any other services that the client is receiving or services for which the client is receiving funds to purchase.

B. When the PAR is disapproved, in whole or in part, the Department or its agent shall notify the case management agency or hospital discharge planner, and the case management agency or hospital discharge planner shall notify the client of the adverse action and their appeal rights on a state-prescribed form, according to Section 8.057, et seq., RECIPIENT APPEALS AND HEARINGS. The denial of a Prior Authorization Request is an adverse action with respect to the client and

may be appealed pursuant to Section 8.057 but cannot be appealed by the provider.

C. Approval of the PAR by the Department or its agent shall authorize providers of services under the case plan to receive payment for properly submitted claims. Payment is conditional upon the client financial eligibility for long term care medical assistance (Medicaid) on the dates of services.

8.515.19 DEPARTMENT CALCULATION OF COST-CONTAINMENT AMOUNT

The Department shall compute the equivalent average daily cost of hospital care for the person with a brain injury by averaging the reimbursement paid for the prior fiscal year for the eight (8) Diagnostic Related Groups pertinent to brain injury. The average expense of providing home and community based services, plus the average daily per capita expenditures for all other Medicaid services provided to these patients, must be equal to or less than the average cost of hospital level of care plus the average per capita expenditures of all other Medicaid services provided to these patients while residing in a hospital.

8.515.20 LIMITATIONS ON PAYMENT TO FAMILY

A. In no case shall any person be reimbursed to provide HCBS-BI services to his or her spouse.

B. Family members other than spouse or parent of a minor child may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-BI program subject to the conditions below. For purposes of this section, family is defined as all persons related to the client by virtue of blood, marriage, adoption or common law.

C. The family member must meet all requirements for employment by a certified personal care agency, and must be employed and supervised by the personal care agency.

D. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

1. The total number of Medicaid personal care units for a family member, shall not exceed an average of 222 personal care units per six-month certification or the equivalent of 444 personal care units for a one-year certification for HCBS-BI. The relative personal care units shall be calculated by multiplying the number of days covered for the certification period by 1.2164 units, to determine the total amount of reimbursement to a family member, and dividing by the number of days covered by the care plan, to determine the average Medicaid cost per day. Family members must average at least 1.2164 hours of care per day (as indicated on the client’s care plan) in order to receive the maximum reimbursement.

2. When HCBS funds are utilized for reimbursement of personal care services provided by the client's family, the home care allowance can not be used to reimburse the family.

8.515.21 CLIENT RIGHTS

The hospital discharge planner shall inform persons eligible for HCBS-B1 of their right to choose between HCBS-BI services and continued hospital care.

The hospital discharge planner or Single Entry Point case manager shall offer persons eligible for HCBS-BI services the free choice of any and all available and qualified providers of appropriate services.

Persons eligible for HCBS-BI shall be entitled to all appeal rights as listed at Section 8.057, et. seq., RECIPIENTS APPEALS AND HEARINGS.

A. The Utilization Review Contractor shall inform the person of appeal rights when the adverse actions concern the level of care or the determination of client target group.

B. The income maintenance technician shall inform the person of appeal rights when the adverse actions concern financial eligibility and shall also notify the hospital discharge planner or single entry point case manager of the adverse action.

C. The case manager shall inform the client of appeal rights for all other adverse actions concerning HCBS-BI eligibility in accordance with Departmental regulations.

The case manager shall assure that persons eligible for HCBS-BI services receive the protection of client rights at Section 8.023.18, CLIENT RIGHTS, LONG TERM CARE SINGLE ENTRY POINT SYSTEM.

8.515.30 HCBS-BI CASE MANAGEMENT FUNCTIONS

A. HCBS-BI PROGRAM REQUIREMENTS FOR SINGLE ENTRY POINT AGENCIES

Single Entry Point agencies must comply with single entry point rules governing case management functions at Section 8.393, et. seq., SINGLE ENTRY POINT SYSTEM, and must, in addition, comply with all specific requirements in the rest of the section on HCBS-BI case management functions.

B. INTAKE/SCREENING/REFERRAL

1. Assessment will be completed by hospital discharge planners and an initial plan of care will be developed prior to the client's release to the community based care.

2. The start date will be the date at which the Utilization Review Contractor approves the assessment and the client is discharged to community based care as defined in 8.515.16. If the applicant is unable to sign due to the medical condition of the applicant, any mark the applicant is capable of making will be accepted in lieu of a signature.

3. Consent to treatment shall be obtained from the client. If the applicant is unable to sign due to their medical condition, any mark that the applicant is capable of making will be accepted in lieu of a signature. If the applicant is not capable of making a mark or if the client is felt to be cognitively compromised to the extent that right to consent should be delegated to a family member, the signature of a family member or other person legally authorized to represent the applicant will be accepted.

4. Hospital staff will verify the individual's current financial eligibility status and initiate a call to the Brain Injury Program Coordinator. This verification shall include whether or not the applicant is in a category of assistance that includes financial eligibility for long term care and shall be confirmed in writing by a DSS-1 form from the county eligibility technician.

5. If financial eligibility is to be determined, the hospital staff will initiate contact with the county department of social services of the client's county of residence for Medicaid application.

C. ASSESSMENT

The discharge planner shall complete the following activities for a comprehensive client assessment:

1. Obtain all required information from the client's physician and inpatient treatment team and/or medical records.

2. Determine the client's functional capacity during a face-to-face interview, preferably with the observation of the client in functional settings outside the hospital environment when possible.

3. Determine the ability and appropriateness of the client's caregiver, family, and other collateral sources, to provide assistance in activities of daily living.

4. Determine the client's service needs, including the client's need for services not provided under HCBS-BI.

5. Review service options based on the client's needs, the potential funding sources, and the availability of resources.

6. Explore the client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with Departmental rules.

7. View and document the current Personal Care Boarding Home license or verify with the Department of Public Health and Environment, if the client lives, or plans to live, in a congregate facility as defined at Section 8.485.50, GENERAL DEFINITIONS, in order to assure compliance with Section 8.485.20, KEYS AMENDMENT COMPLIANCE.

8. Determine and document client preferences in program selection.

9. The case manager shall assure that:

    a. The ULTC-100.2 assessment and plan of care is completed within two days of the hospital being notified that an applicant may be functionally eligible for the Brain Injury Waiver Program.

    b. The Long Term Care Professional Medical Information section of the ULTC. 100.2 is completed by the individual's attending physician' office. A completed form shall include the provider's name and address, and the name and title of the person providing the information.

    c. A completed copy of the ULTC 100.2 is submitted to the State Brain Injury Program Administrator and to the County Department of Human Services eligibility technician to notify them of admission into the HCBS-BI program.

D. HCBS-BIDENIALS

HCBS-BI services cannot be paid for if a person is determined, at any point in the assessment process, to be ineligible for the following reasons:

1. Financial Eligibility

    The income maintenance technician shall notify the applicant of denial for reasons of financial eligibility, and shall inform the applicant of appeal rights in accordance with the Colorado Department of Human Services Staff Manual Volume 3, INCOME MAINTENANCE. The case manager shall not attend the appeal hearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the State.

2. Level of Care and Target Group Denials

    a. The URC/SEP agency shall notify the applicant of denial for reasons related to determination of level of care and target group eligibility, and shall inform the

applicant of appeals rights in accordance with Section 8.8.057.

b. The URC/SEP case manager shall attend the appeal hearing to defend any denial action.

3. Continued Stay Review Denials

a. For a client who has been receiving services under the HCBS-BI Waiver program, the URC/SEP case manager shall notify the client pursuant to Section 8.057.

b. The URC/SEP case manager shall attend the hearing to defend the denial action of continued program eligibility.

4. Cost-effectiveness

Depending upon the timing of the denial of further services due to cost-effectiveness criteria, the SEP case manager shall notify the applicant of denial, on a State-prescribed form, when it is determined that the applicant does not meet the eligibility requirement at 8.515.19 for COST-EFFECTIVENESS and shall inform the applicant of appeal tights in accordance with Section 8.057 RECIPIENT APPEALS AND HEARINGS. The case manager shall also attend the appeal hearing to defend this denial action. If the applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the applicant, and the competency of the applicant to choose to live in an unsafe situation. If the case manager determines that the applicant will be unsafe with the amount of services available, and that the applicant is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-BI eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the client's physician attesting to the client's mental competency status, and all other available information which will support the determination that the client is unsafe and incompetent to make a decision to live in an unsafe situation; and which will satisfy the burden of proof required of the case manager making the decision. Denials and appeals for reasons of cost effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the Utilization Review Contractor in regard to level of care and target group determination.

5. Institutional Status

The case manager shall notify the applicant of denial, on a Departmentally prescribed form, when the case manager determines that the applicant does not meet the eligibility requirement at Section A.4, 8.515.15, INSTITUTIONAL STATUS, and shall inform the applicant of appeal rights in accordance with Section 8.057 et., seq., RECIPIENT APPEALS AND HEARINGS. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the Utilization Review Contractor in regard to level of care and target group determination.

E. CARE PLANNING

The hospital discharge planner shall initiate development of the care plan after completing the client assessment and shall complete the care plan (including all required paperwork) prior to discharge. Care Planning shall include, but not be limited to, the following tasks:

1. Identification and documentation of care plan goals and client choices;

2. Identification and documentation of all services needed, including type of service, specific functions to be performed, frequency and amount of service, type of provider, funding source, and services needed but not available.

3. Documentation of the client's choice of HCBS-BI services or continued hospitalization including a signed statement of choice from the client or authorized representative;

4. Documentation that the client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the client understands his/her right to change providers;

5. The formalization of the care plan agreement of a Long Term Care Plan, including appropriate signatures. If the applicant is unable to sign due to a medical or cognitive condition, any mark that the applicant is capable of making will be accepted in lieu of a signature. If the applicant is not capable of making a mark, the signature of a family member or other person authorized to represent the applicant is acceptable.

6. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the client regarding service provision.

7. The inclusion of a process, developed in coordination with the eligible client and the client's family or guardian, by which the client may receive necessary care if the client's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The client and the client's family or guardian shall be duly informed of these alternative care provisions at the time the plan of care is initiated.

8. Referral to community resources as needed and development of resources for individual clients if a resource is not available within the client's community.

9. Referral to state brain injury program coordinator for an explanation of complaint procedures to the client.

When developing the care plan, the discharge planner shall make every effort to ensure that there is no duplication between those services requested under HCBS and services from any other funding source. This includes, but is not limited to, services provided or paid for through Home Health, Home Care Allowance, Veteran's Aid and Attendance, or Assisted Living Residence.

F. CALCULATION OF CLIENT. PAYMENT (PETI)

This section explains responsibilities for calculation of PETI; for further information on the process of calculation and allowances, please refer to Section 8.515.17.

The case manager shall calculate the PETI client payment for 300% eligible HCBS-BI clients according to the following procedure:

For 300% eligible HCBS-BI clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required.

For 300% eligible HCBS-BI clients who are residing temporarily in Transitional Living Centers, the case manager shall complete. a State-prescribed form which calculates the client payment according to specifications delineated for Alternate Care Facility clients according to Section 8.486.60 et. seq., CALCULATION OF CLIENT PAYMENT (PETI).

G. PRUDENT PURCHASE AND SERVICE FUNDING PRIORITIES.

1. The discharge planner or case manager shall attempt to meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

2. Diligent effort will be made to assist the client in making informed choices by:

    a. Presenting/outlining available service providers/options and providing a brief description of that service category in written format;

    b. Assisting the family and client in weighing various factors in the selection of provider; and

    c. Maintaining current and accurate knowledge of various community resources.

3. When services are available to the client at no cost from family, friends, volunteers or others, these services shall be utilized before the purchase of services, providing these services adequately meet the needs of the client and do not constitute an undue hardship on the family through the exhaustion of financial or emotional resources.

4. When public dollars must be used to purchase services, the discharge planner or case manager shall encourage the client to make the most efficient use of the services available by selection of the lowest cost provider of service where quality of service is comparable.

H. COST CONTAINMENT

The hospital discharge planner shall determine whether the person can be served at or under the cost ceiling for hospital based service for an individual recipient by using a departmentally prescribed form to:

1. Determine the maximum authorized costs for all HCBS-BI services for the period of tune-covered by the case plan, and compute the average cost per day by dividing the number of days in the case plan period; and

2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount.

I. SUBMISSION OF PRIOR AUTHORIZATION REQUESTS

This section describes responsibilities for submission of prior authorization within the functions of case management; for further information regarding the processing of prior authorization requests, please refer to Section 8.515.18.

1. Discharge planners and case managers shall submit Prior Authorization Requests for transitional living, nonmedical transportation, environmental modifications, and assistive equipment only.

2. Every PAR shall include the Care Plan and the Prior Approval Request. For prior authorization of transitional living services, a tentative treatment plan and evaluation from the probable provider shall be submitted with the PAR. All units of service requested on the Prior Approval Request must be listed on the Care Plan. If a range of units is estimated on the care plan, the number of units at the higher end of the range may be requested on the Prior Approval Request.

3. If a PAR includes a request for environmental modification services, the PAR shall also include all documentation listed at Section 8.516.00, ENVIRONMENTAL MODIFICATION.

4. The start date of the prior authorization request form shall never precede the start date of eligibility for HCBS-BI services according to Section 8.515.16.

5. The PAR shall not cover a period of time longer than the length of stay assigned by the Utilization Review Contractor.

6. If a PAR is returned for corrections, the corrected PAR must be returned to the Department or its agent within two days after the discharge planner received the notification letter of correction.

J. COORDINATION, MONITORING, AND EVALUATION OF SERVICES

1. The case manager shall monitor the services that are being provided, the appropriateness and effectiveness of services provided, the amount of care, the timeliness of service delivery, the client's satisfaction, the safety of the client, and shall take corrective actions as needed. Monitoring contacts must occur and be documented at least once every month, or more frequently as determined by the client's needs and single entry point agency policy.

2. The case manager shall contact each client on a face-to-face basis at least once every three months, or more frequently as determined by the client's needs and single entry point agency policy during the initial year of program participation.

3. On-going case management shall include, but not be limited to, the following tasks:

    a. Review of the client's case plan and service agreements.

    b. Contact with the client concerning whether services are being delivered according to the plan; and the client's satisfaction with services provided.

    c. Contact with service providers to verify that services are being delivered according to the plan; and concerning service coordination, effectiveness and appropriateness, as well as to inquire into and/or remedy any complaints raised by the client, family members, caregivers or others who are involved in the immediate support of the recipient.

    d. Contact with caregivers, family members, or significant others in the recipient's immediate support system in the event any issues or complaints have been presented through the process of monitoring and sampling the recipients satisfaction with care provided through the HCBS-BI program

    e. Conflict resolution and or crisis intervention, as needed.

    f. Informal assessment of changes in client functioning, service effectiveness, service appropriateness, and service cost effectiveness.

    g. Notification of appropriate enforcement agencies, as needed.

    h. Referral to community resources, and arrangement for non-HCBS-BI services as needed.

4. In the event, at any time throughout the case management process, the case manager

suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.

5. REVISIONS ADDED TO THE CASE PLAN

    a. Whenever a change in the care plan results in an increase or change in the services to be provided, the case manager shall provide a revised care plan listing the services being revised and the reason for revision. A Revised cost containment sheet must be submitted reflecting resultant changes/Calculations

    b. If additional services include any one of the previously listed services requiring prior authorization, the case manager must submit a prior authorization request according to Section 8.515.30.

K. REASSESSMENT

1. The case manager shall complete a reassessment of each HCBS-BI client before the end of the length of stay assigned by the Utilization Review Contractor at the last level of care determination. The case manager shall initiate a reassessment more frequently when warranted by significant changes that may affect HCBS-BI eligibility. In addition, a reassessment shall be completed every six months for the first year, and annually thereafter.

2. The case manager shall complete the reassessment, utilizing the ULTC 100.2 Assessment form.

3. Reassessment shall include, but not be limited to, the following activities:

    a. Verify continuing Medicaid eligibility, including verification of an aid category mat includes eligibility for long term care benefits.

    b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;

    c. Evaluate continuing need for the HCBS-BI program, and clearly document reasons for continuing HCBS-BI, transfer to the HCBS-EBD, HCA or other program, or terminate the client's eligibility according to Section 8.515.30, M.

    d. Reassess the client's functional status, according to the procedures in Section 8.515.30, C, ASSESSMENT.

    e. Review the care plan, including verification of whether services have been delivered according to the case plan, and write a new case plan, according to procedures at Section 8.515.30, E, CARE PLANNING.

    f. Refer the client to community resources as needed; and

    g. Submit the complete and correct ULTC 100.2 Assessment to the Utilization Review Contractor for a continued stay review, in accordance with the guidelines at ASSESSMENT.

L. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

Single entry point agencies shall comply with the procedures as detailed in 8.39332, A, et. seq., INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES for transferring clients to another county or single entry point district

M. DISCONTINUATION OF SERVICES

1. Clients shall be discontinued from the HCBS-BI program whenever they no longer meet one or more of the eligibility requirements in section 8.515.15 ELIGIBLE PERSONS. Clients shall also be discontinued from the program if they die , move out of state or voluntarily withdraw from the program; or if the client's physician fails to sign a required assessment form

2. Clients who are discontinued from HCBS-BI because they no longer immediately of the termination and their appeal rights as follows:

   a. Financial Eligibility

      Procedures at Section 8.393.28 HCBS-EBD DENIALS shall be followed for discontinuation for this reason.

   b. Level of Care and Target Group

      Procedures at Section 8393.28, HCBS-EBD DENIALS shall be followed for discontinuation for this reason.

   c. Receiving HCBS-BI Services

      Procedures at Section 8.393.28 HCBS-EBD DENIALS shall be followed for discontinuation for this reason.

   d. Institutional Status

      Procedures at Section 8.393.28 HCBS-EBD DENIALS shall Procedures at Section 8.393.28 HCBS-EBD DENIALS shall the Department shall assume responsibility for than the single entry point agency case manager.

   e. Cost Effectiveness

      Procedures at Section 8.393.28 HCBS-EBD DENIALS shall be followed for discontinuations for this reason, except that the Department shall assume responsibility for communicating the decision via an advisement letter rather than the single entry point agency case manager.

N. COMMUNICATION

Communication requirements of case management functions within single entry point agencies will comply with all provisions of 8.393.28.

O. CASE RECORDING DOCUMENTATION

Documentation standards and requirements for the HCBS-BI program must comply with Section 8.393.26, et seq., of this Staff Manual.

8.515.40 HCBS-BI Provider Agencies

A. GENERAL CERTIFICATION STANDARDS

1. Provider agencies shall conform to all State established standards for the specific services they provide under this program, shall abide by all the terms of the provider agreement with the State, and shall comply with all federal and state statutory requirements. A provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Provider agencies shall have written policies and procedures for recruiting, selecting, retaining, training, and terminating employees.

3. Provider agencies shall have written policies governing access to duplication and dissemination of information from the recipient's records in accordance with state statutes on CONFIDENTIALITY OF INFORMATION at 26-1-114, C.R.S. as amended. Provider agencies shall have written policies and procedures for providing employees with client information needed to provide the services assigned, within the agency policies for protection of confidentiality.

4. Provider agencies shall maintain liability insurance in at least such minimum amounts as set annually by the Department, and shall have written policies and procedures regarding emergency procedures.

5. Provider agencies shall provide written human rights and post same in a readily visible area. Residents of Supportive Living Care facilities who believe their rights have been denied may request the assistance of the facility; contact the case manager, local ombudsman, or the resident’s legal representative. Any case, which cannot be resolved through these routes, may be referred to the Department for a final determination.

6. Provider agencies shall have written individualized treatment plans for each client with goals and objectives based on the clients needs. Progress toward goals shall be monitored and reported in objective measurable terms on a weekly basis. If a client is receiving services in a transitional living center, formal progress reports should be submitted on a bimonthly basis to the case manager. For other service providers, formal progress reports shall be submitted to the referring case manager on a semi-annual or an annual basis. The interdisciplinary team or professional, the client, and the family, when appropriate will mutually develop treatment goals.

7. Specific treatment modalities outlined in the treatment plans shall be systematically implemented with techniques that are consistent, functionally based, and active throughout the treatment period. Methods shall be appropriate to the goals, and treatment plans shall be reviewed and modified as appropriate. Goals of treatment shall reference outcomes in the degree of personal and living independence, work productivity, and psychological, social, and physical adjustment.

8. Initial assessment and progress shall be communicated to the client, the family and the referral source regularly in a manner that can be easily understood. The client and his/her family shall be offered a copy of the treatment plan and the client's signature shall be obtained on the care plan.

9. Provider agencies shall have written policies and procedures regarding the handling and reporting of critical incidents, including accidents, suspicion of abuse, neglect or exploitation, and criminal activity.

10. Provider agencies shall maintain a log of all complaints and critical incidents, which shall

include documentation of the resolution of the problem.

11. Provider agencies shall maintain records on each client. The specific record for each client must include at least the following information:

    a. Name, address, phone number and other identifying information about the client.

    b. Name, address and phone number of the discharge planner, case manager and case management agency.

    c. Name, address and phone number of the client's primary care physician.

    d. Special health needs or conditions of the recipient.

    e. Documentation of any changes in the client's condition or needs, as well as documentation of appropriate reporting and action taken as a result.

    f. Documentation of the services provided, including where, when, to whom and by whom the service was provided, and the exact nature of the specific tasks performed as well as the amount or units of service.

    g. Documentation of supervision of care.

    h. All information regarding a client must be kept together for easy access and review by supervisors, program monitors and auditors.

    i. If a resident receives compensation from the facility it shall be done in accordance with 10-CCR 2505-10 §8.495.82.

12. Provider agencies shall maintain a personnel record for each employee. The employee record must contain a copy of the employee's job description, documentation of employee training, education, certification or licensure and work experience which qualifies them to provide the requisite service to people with brain injury, and documentation of supervision and performance evaluation.

13. Personnel records for each employee or volunteer must include name, age, sex, home address and phone number, and results of TB testing for any employee or volunteer providing direct care to Supported Living or Transitional Living residents or involved in meal preparation or food handling.

14. A provider agency may become separately certified to provide more than one type of HCBS-BI service if all requirements are met for each certification. Administration of the different services provided shall be clearly separate for auditing purposes. The provider agency must also understand and be able to articulate its different functions and roles as a provider of each service, as well as all the rules that separately govern each of the types of services, in order to avoid confusion on the part of the clients and others.

15. Provider agencies shall send billing and other staff to the provider automated medical payment training offered by the fiscal agent, at least once each year.

16. An agency as defined in 8.515.14 A. GENERAL DEFINITIONS seeking certification as an HCBS-BI provider, shall submit a request to the Department of Health Care Policy and Financing or its agent.

17. Upon receipt of the request the Department or its agent shall forward certification information

and relevant departmental application forms to the requesting agency.

18. Upon receipt of the completed application from the requesting agency, the Department of Health Care Policy and Financing or its agent shall review the information and complete an on-site review of the agency, based on the departmental regulations for the service for which certification has been requested.

19. If a provider holds a current Commission on the Accreditation of Rehabilitation Facilities (CARF) accreditation for a specific program, the Department or its agent may consider that to satisfy a portion of the certification requirements as a Supported Living program provider. CARF re-accreditation shall occur annually or as required by CARF.

20. care or assisted living facilities and life safety, fire and building codes. All inclusions at 8.495.20 apply to Supported Living providers. Refer to Alternative Care Facilities regulations at 10 CCR-2505-10 §8.495.54-.57 and 8.495.72.L, 8.495.116 & .117, 8.495.130, .140, .180 and .191.

21. Following completion of the on-site review the Department or its agent shall notify the provider agency applicant of its recommendation by forwarding the results of the on site survey and its recommendation of approval, denial, or provisional approval of certification and if appropriate, request a corrective action plan to satisfy the requirements of a provisional approval

22. Determination of certification approval, provisional approval or denial shall be made by the Department within thirty days of receipt of the completed application from the agency or from the completion of the survey.

B. APPROVAL OF CERTIFICATION

If certification is approved, the agency shall initiate an agreement with the state's fiscal agent to implement the automated medical payment system (AMPS) and execute a provider agreement with the Department of Health Care Policy and Financing.

C. If a Supportive Living provider holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for a specific program, the Department may deem certification for that program. CARF re-accreditation shall occur yearly.

D. PROVISIONAL APPROVAL OF CERTIFICATION

If agencies do not meet all Department established certification standards, but the deficiencies do not constitute a threat to client's health and safety, such agencies may be provisionally certified for a period not to exceed sixty days at the discretion of the Department.

If provisional approval has been granted, the Department or its agent shall assure that corrective action has been taken according to the approved plan, and shall conduct an on-site review, if necessary, within the designated time period.

E. DENIAL OF CERTIFICATION

If the agency is unable to complete an adequate corrective action plan within the prescribed time, certification shall be denied.

F. RECERTIFICATION PROCESS

Initial certification shall be for a period of one year. No later than thirty days prior to the end of the

current certification, the department shall notify the provider agency of the certification decision, which may be certification, provisional certification, or denial of certification. The Department or its agent shall follow the same procedures as those followed for certification, as described at 8.487.20 GENERAL CERTIFICATION.

G. TERMINATION OR NON-RENEWAL OF PROVIDER AGREEMENTS

The Department shall initiate termination or non-renewal of a provider agreement if an agency is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The Department shall follow procedures at 8.130, PROVIDER AGREEMENTS.

H. EMERGENCY TERMINATION OF PROVIDER AGREEMENTS

Emergency termination of any provider agreement shall be in accordance with procedures at 8.050 PROVIDER APPEALS AND HEARINGS.

I. TRANSFER OF OWNERSHIP

The provider shall notify the department or its agent within five working days of any change of ownership. Upon transfer of ownership of the provider agency or facility, the new provider must initiate a new agreement with the Department.

J. PROVIDER RIGHTS

The Department shall notify provider agencies in writing of any adverse action taken by the State against the agency, and shall inform the agency of its appeal rights in accordance with the procedures described in Section 8.050.

K. PROVIDER REIMBURSEMENT

1. Payment to certified HCBS-BI providers for services provided to eligible clients shall be made when claims are submitted in accordance with the following procedures.

    a. Claims shall be submitted to the fiscal agent on Department prescribed formats through the automated medical payment system if available.

    b. Claims shall be submitted in complete and correct format.

    c. Payment shall not exceed departmental limits as described under the reimbursement sections for each HCBS-BI service.

    d. Payment shall be made only for the service or services for which the agency is certified;

    e. Payment shall be made only for the types and amounts of services that are authorized.

    f. Payment shall be made only for services provided by persons employed by the agency at the time the services were provided.

    g. For services of transitional living, behavioral programming, nonmedical transportation, assistive and special equipment, and environmental modifications, prior authorization is required, and reimbursement will be made only if the prior authorization process has been followed.

2. Provider agencies shall maintain adequate financial records for all claims, including documentation of services as specified at Section 8.040.02, RULES GOVERNING SUBMISSION OF CLAIMS, Section 8.130, PROVIDER AGREEMENTS, and Section 8.487.10 GENERAL CERTIFICATION STANDARDS.

3. Supportive Living services shall be a per diem reimbursement negotiated with the Department that follows a tiered rate methodology. The methodology shall be based on the provider's mix of client functional acuity scores and the services received. Supportive Living providers shall submit functional acuity scores to the Department twice per year on December 1 and June 1. The providers shall utilize the Department approved functional acuity tool for each HCBS-BI client.

8.515.50 ASSISTIVE AND SPECIAL MEDICAL EQUIPMENT

A. DEFINITIONS

Specialized medical equipment and supplies includes devices controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Assistive Devices include equipment which meets one of the following criteria:

1. Is useful in augmenting an individual's ability to function at a higher level of independence and lessen the number of direct human service hours required to maintain independence;

2. Is necessary to ensure the health, welfare and safety of the individual;

3. Enables the individual to secure help in the event of an emergency;

4. Is used to provide reminders to the individual of medical appointments, treatments, or medication schedules; or

5. Is required because of the individual's illness impairment or disability, as documented on the screening assessment form and the plan of can.

B. INCLUSIONS

1. Items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

2. Items which are not of direct medical or remedial benefit to the recipient are excluded.

3. Assistive devices to augment cognitive processes, "cognitive-orthotics" or memory prostheses are included in this service area. Examples of cognitive orthotic devices include informational data bases, spell checkers, text outlining programs, timing devices, security systems, car finders, sounding devices, cuing watches, telememo watches, paging systems, electronic monitoring, tape recorders, electronic checkbooks, electronic medication monitors, and memory telephone.

C. CERTIFICATION REQUIREMENTS

Certification standards refer to both the supplier of equipment as well as the actual product or equipment itself.

1. All items shall meet applicable standards of manufacture, design and installation.

2. All equipment materials or appliances used as pan of monitoring systems shall carry a UL (Underwriter's Laboratory) number or an equivalent standard.

3. All telecommunications equipment shall be FCC registered.

4. All equipment materials, or appliances shall be installed by properly trained individuals, and the installer shall train the client in the use of the device.

5. All equipment, materials or appliances shall be tested fir proper functioning at the time of installation and at periodic intervals thereafter by a properly trained individual.

6. Any malfunction shall be promptly repaired by a properly trained technician supplied at the provider agency's expense. Equipment shall be replaced when necessary, including buttons and batteries.

7. Assistive equipment providers shall send written information to each clients case manager about the item, how it works, and how it should be maintained.

D. REIMBURSEMENT METHOD FOR ASSISTTVE DEVICES

Reimbursement for assistive devices will be on a per unit basis. If assistive devices are to be used primarily in a vocational application, devices should be funded through the Division of Vocational Rehabilitation with secondary funding from Medicaid.

8.515.60 PERSONAL CARE SERVICES

A. DEFINITION

Personal care services means services which are furnished to an eligible client in the client's home to meet the client's physical maintenance and support needs, when those services are not skilled personal care as described in the exclusions section below, do not require the supervision of a nurse, and do not require physician's orders. Assistance may include eating, bathing, dressing, personal hygiene, and activities of daily living.

1. Personal care provider means a provider agency as defined at Section 8.485.50(Q), GENERAL DEFINITIONS, which has met all the certification standards for personal care provider listed below.

2. Personal care staff means those employees of the personal care provider agency who perform the personal care tasks.

3. Skilled personal care means skilled care which may only be provided by a certified home health aide, as further defined at Section 8.520, HOME HEALTH SERVICES.

4. Unskilled personal care means personal care which is not skilled personal care, as defined above.

B. INCLUSIONS

All inclusions listed in Section 8.489 apply.

C. EXCLUSIONS AND RESTRICTIONS

All exclusions and restrictions listed in Section 8.489 apply.

D. CERTIFICATION STANDARDS

All certification standards for personal care services listed in Section 8.489 apply to the HCBS-BI waiver program providers.

E. REIMBURSEMENT

1. Payment for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Total daily charges for personal care can not exceed the sum of ten hours of care. Reimbursement shall be per unit of one hour.

2. Payment may include travel time to and from the client's residence, to be billed under the same procedure code and rate as personal care services. The time billed for travel shall be listed separately from, but documented on the same form as, the time for service provision on each visit Travel time must be summed for the week and then rounded to the nearest hour for billing purposes. If the travel time to and from a client's residence is 15 minutes one way-30 minutes round trip, then the travel time for one week shall be 210 minutes (rounded up to 4 hours) for the week.

3. When personal care services are used to provide respite for unpaid primary care givers, the exact services rendered must be specified in the documentation.

4. When an employee of a personal care agency provides services to a client who is a relative, the personal care agency shall bill under a special procedure code, in hourly units, using rates and hours which shall not exceed a maximum of 222 units per 6 month certification, when averaged out over the number of days in the 6 month plan period or 444 units per 12 month certification.

5. If a visit by a Home Health Aide employed by a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed.

8.515.70 ADULT DAY SERVICES

A. DEFINITIONS

1. Adult Day Services means both health and social services furnished on a regularly scheduled basis in an adult day services center two or more hours per day, one or more days per week to ensure the optimal functioning of the client Services are directed towards recreation and socialization as well as maintaining a safe and supportive environment.

2. Adult Day Services Center means a non-institutional entity that conforms to requirements for maintenance

3. Maintenance Model means services in health monitoring and individual and group therapeutic and psychological activities which serve as an alternative to long-term nursing home care.

4. Adult day services include:

   a. Daily monitoring to assure that clients are maintaining personal hygiene and participating in age appropriate social activities as prescribed; and assisting with activities prescribed; and assisting with activities of daily living (e.g., eating, dressing).

b. Emergency services including whiten procedures to meet medical crises.

c. Assistance in the development of self-care capabilities personal hygiene, and social support services.

d. Provision of nutritional needs appropriate to the hours in which the client is served.

e. Nursing services as necessary to supervise medication regimen of trained medication aides and carry out any of the services listed as SKILLED CARE in SECTION 8.489.30.

f. Social and recreational services as prescribed to meet the client's needs.

g. Any additional services if such services are included in the budget submitted to the Department in accordance with the section on REIMBURSEMENT METHOD FOR ADULT DAY CARE below, and determined by the Department to be necessary for adult day care.

B. CERTIFICATION STANDARDS

All adult day service centers shall conform to all of the following Departmental standards

1. All providers must conform to all established departmental standards in the general certification standards section.

2. All providers of adult service care shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.

3. The agency shall provide a clean environment, free of obstacle; that could pose a hazard to client health and safety.

4. Agencies shall provide lockers or a safe place for clients' personal items.

5. Adult day service centers shall provide recreational areas and activities appropriate to the number and needs of the recipients.

6. Drinking facilities shall be located within easy access to residents.

7. Adult day service centers shall provide eating and resting areas consistent with the number and needs of the clients being served.

8. Adult day service centers shall provide easily accessible toilet facilities, hand washing facilities and paper towel dispensers.

9. The center shall be accessible to clients with supportive devices for ambulation or who an in wheelchairs.

C. RECORDS AND INFORMATION

Adult day service providers shall keep such records and information necessary to document the services provided to clients receiving adult day services. Medical Information Records shall include but not be limited to:

1. Medications the client is taking and whether they are being self-administered.

2. Special dietary needs, if any.

3. Restrictions on activities identified by physician in the case plan.

D. STAFFING

All adult day service centers shall have staff who have been trained in current cardiopulmonary resuscitation, seizure prophylaxis and control and brain injury. Adequate staff shall be on the premises at all times to ensure:

1. Supervision of clients at all times during the operating hours of the program.

2. Immediate response to emergency situations to assure the welfare of clients.

3. Provision of prescribed recreational and social activities.

4. Provision of administrative, recreational, social and supportive functions of the adult day services center.

E. POLICIES

The center shall have a written policy relevant to the operation of the adult day services center. Such policy shall include but not be limited to statements describing:

1. Admission criteria that qualify clients to be appropriately served in the center.

2. Interview procedures conducted for qualified clients and/or family members prior to admission to the center.

3. The meals and nourishments that will be provided, including special diets.

4. The hours that the clients will be served in the center and days of the week services will be available.

5. The personal items participants may bring with them to the center.

6. A written signed contract to be drawn up between the client or responsible party and the center outlining rules and responsibilities of the center and of the client Each parry of the contract will have a copy.

7. A statement of the center's policy for providing drop in care or day respite.

F. REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

1. Reimbursement for adult day services shall be based upon a single a single all-inclusive payment rate per unit of service for each participating provider.

2. Each provider will be paid on a per diem statewide uniform rate. The rate of payment shall be subject to available appropriations and may be the lower of the billed amount or the Medicaid allowable rate which is determined by multiplying the number of units times a rate established by the Department

8.515.80 DAY TREATMENT

A. DEFINITION

Day Treatment means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the recipient lives.

B. PROGRAM COMPONENTS, POLICIES AND PROCEDURES

1. Treatment plans are coordinated by a comprehensive interdisciplinary team which includes the recipient and his/her family and provides for consolidation of services in one location.

2. Professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, social work, recreational therapy, case management, and neuropsychology should be directly available from the provider or available as contracted services when deemed medically necessary by the treatment plan.

3. Certified occupational therapy aides, physical therapy aides, and communication aides may be used in lieu of direct therapy with fully licensed therapists to the extent allowed in existing state statue.

4. The provider shall network with all allied medical professionals and other community based resource providers.

5. Services include social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for community reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management).

6. Crisis situations with family, client or staff shall be addressed through counseling and referral to appropriate professionals.

7. Behavioral programs shall contain specific guidelines on treatment parameters and methods.

8. There shall be regular contact and meetings with the clients and their families to discuss treatment plan progress and revision.

9. Discharge planning will include the development of a plan which considers safety, environmental modification to support individual function, education of the family and caregiver, recommendations for the future, and referral to additional community resources.

10. Each entity must have a process, verified in writing, by which a client is made aware of the process for filing a grievance.

11. Complaints by the client or family are handled within a 24 hour period from the time of complaint by at least telephone contact.

12. Transportation between therapeutic tasks in the community shall be included in the per diem cost of day treatment.

13. There shall be an inform and consent mechanism by which the client, family medical proxy or substitute decision maker is made aware of the inherent risks associated with community based rehabilitation programs. Examples of such risks might include a greater likelihood of falling accidents, traffic hazards and access to drugs or alcohol.

C. HUMAN RIGHTS

Every person receiving HCBS-BI services has the following rights:

1. Every person shall mutually develop and sign their treatment plan.

2. Every person has the right to enjoy freedom of thought, conscience, and religion.

3. Every person has the right to live in a clean, safe environment.

4. Every person has the right to have his or her opinions heard and be included, to the greatest extent possible when any decisions are being made affecting his her life.

5. Every person has the right to be free from physical abuse and inhumane treatment.

6. Every person has the right to be protected from all forms of sexual exploitation.

7. Every person has the right to access necessary medical care which is adequate and appropriate to their condition.

8. Every person has the right to communicate with significant others.

9. Every person has the right to reasonable enjoyment of privacy in personal conversations.

10. Every person has the right to have access to telephones, both to make and receive calls in privacy.

11. Every person has the right to have frequent and convenient opportunities to meet with visitors.

12. Every person has the right to the same consideration and treatment as anyone else regardless of face, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status, or disability.

13. Every person who acts as his own legal guardian has the right to accept treatment of his/her own free will.

14. Nothing in this pan shall be construed to prohibit necessary assistance as appropriate, to those individuals who may require such assistance to exercise their rights.

15. Every person has the right to be free of physical restraint unless physical intervention is necessary to prevent such body movement that is likely to result in imminent injury to self or others, and only if alternative techniques have failed. Mechanical restraints are not allowed.

D. DOCUMENTATION

1. Intake information shall include a complete neuropsychological assessment and all pertinent medical documentation from inpatient and outpatient therapy and social history to identify key treatment components and communicate the functional implications of treatment goals.

2. Initial treatment plan development and evaluations will occur within a two week period following admission.

3. Treatment plan goals and objectives shall reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social

adjustment, quality of life and degree of community participation.

4. Specific treatment modalities outlined in the treatment plan shall be systematically implemented with techniques that are consistent, functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and treatment plans will be reviewed and modified as appropriate.

5. Progress notes will be kept to support specific treatment modalities rendered by date and signed by the therapist providing the service.

E. CERTIFICATION STANDARDS

1. Directors of day treatment programs shall have professional licensure in a health related program in combination with at least 2 years of experience in head trauma rehabilitation programming.

2. All providers shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.

3. The agency shall provide a clean environment, free of obstacles that could pose a hazard to client health and safety.

4. Agencies shall provide lockers or a safe place for clients' personal items.

5. Day treatment centers shall provide age appropriate activities and provide eating and resting areas consistent with the number and needs of the clients being served.

6. The center shall be accessible according to guidelines established by the Americans with Disabilities Act.

7. Personnel shall have training appropriate to the medical needs of the clients served including seizure management training, CPR certification, non-violent crisis intervention, and personal care standards according to SECTION-PERSONAL CARE 8.489.40.

F. REIMBURSEMENT

Day treatment services will be paid on a per diem basis at a rate to be determined by the Department In order for a provider to be paid for a day of treatment, a client must have attended and received therapeutic intervention which is substantiated by case file notes signed by the rendering therapist

8.515.90 RESPITE CARE

A. DEFINITIONS

Respite Care means an organized program whose purpose is to sustain the family or other primary caregiver of persons with brain injury by providing those individuals with time-limited and temporary relief from the ongoing responsibility of care. Services may be provided on a scheduled basis or in response to a crisis or emergency.

Respite care providers are trained personnel in a variety of settings including skilled nursing facilities, hospitals, drop in resource centers, and certified respite providers or any other facility which meets the certification standards for respite care specified below.

B. INCLUSION

Families will be eligible for unlimited days of respite care per year.

C. EXCLUSION

If the waiver participant is in a transitional living residence, Supported Living Care facility or out-of-home placement, no respite care services will be provided while the waiver recipient is in the transitional living program.

D. POLICIES

1. The information provided at referral and the medical, social, psychological and other information available should vary according to the circumstances for which respite is being sought, including the extent of the crisis or emergency present in the referral and the duration and scope of the Respite Program.

2. The design and schedule of the respite services is variable and should be based upon the needs and convenience of both the person with brain injury and his/her family or primary caregiver, whenever possible.

3. The program should minimize the disruption in the continuity of living patterns which may be created by the respite services.

E. CERTIFICATION STANDARDS

1. The nursing facility must have a valid contract with the Department as a Medicaid certified nursing facility. Such contract shall constitute an automatic certification for HCBS-BI respite care. A respite care provider billing number shall be issued to all certified nursing faculties.

OR

Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services must meet the same competency standards as all other providers and be employed by the certified provider agency.

2. The respite program shall have or be part of a risk protection program that includes appropriate insurance, screening of personnel, ongoing training of personnel to enhance skills, and supervision.

3. If 24-hour respite services are provided by the organization at its own location, the living quarters should be homelike, age appropriate, and culturally sensitive and in compliance with all Assisted Living Residence regulations.

F. REIMBURSEMENT

1. Respite care reimbursement to nursing facilities shall be according to procedures identified in 8.492.50.

2. Nursing facilities shall agree to accept Medicaid reimbursement as full and final payment for respite services and are not allowed to solicit personal needs allowance monies from the client or his/her family.

3. Individual respite, providers shall bill according to an hourly rate or daily institutional rate, whichever is less.

8.516.00 ENVIRONMENTAL MODIFICATION

A. DEFINITIONS

1. Environmental modification means specific adaptations or installations in an eligible client's home setting which:

   a. Are necessary to ensure the health, welfare, and safety of the individual;

   b. Enable the individual to function with greater independence in the home;

   c. Are required because of the individual's illness, impairment or disability, as documented on the screening assessment and care plan form; and

   d. Prevent institutionalization of the individual.

2. Environmental modification provider means a provider agency as defined at Section 8.515.14 0 GENERAL DEFINITIONS which has met all the certification standards for environmental modification services listed in Section 8.493.40 et seq. CERTIFICATION SERVICES FOR HOME MODIFICATIONS SERVICES.

B. INCLUSIONS

Such adaptations may include:

- the installation of ramps
- installation of grab-bars
- widening of doorways
- modification of bathroom facilities
- installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient.

C. EXCLUSIONS AND RESTRICTIONS

1. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the HCBS-BI program client, such as carpeting, roof repair, central air conditioning, furnace replacement, etc. shall not be approved.

2. If the home modification is estimated to cost $500 or more, the following procedures shall be followed:

   a. An occupational therapist shall assess the client's needs and the effectiveness of the requested home modification and submit a written recommendation. In geographical areas where an occupational therapist is not available, the services of a physical therapist may be substituted. A report specifying how the home modifications would contribute to the person's ability to remain in or to return to his/her home, and how the modification would increase the individual's independence and decrease the need for other services such as personal care, must be completed by the therapist on a Department prescribed form and submitted with a PAR to the Brain injury Program Coordinator.

b. In conjunction with the occupational therapist, the case manager shall first consider less costly alternative methods of addressing the client's needs and shall send documentation of the activity with the Prior Authorization Review.

c. The case manager shall first consider alternative funding sources such as. but not limited to. Worker's Compensation Insurance, private automobile insurance. Medicare, vocational rehabilitation funds and funds raised or provided by volunteer organizations; and shall send documentation of this activity with the PAR.

d. The case manager shall follow a bid process as specified in 8.493.30, D.

e. The Department or its agent may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the request for environmental modification.

f. The Department reserves the right to deny requests for environmental modification that are not reasonable in cost, when compared to usual and customary charges.

g. There shall be a lifetime cap of $10,000 per household on any HCBS Medicaid funds approved for environmental modification services.

D. CERTIFICATION STANDARDS FOR ENVIRONMENTAL MODIFICATIONS

1. Environmental Modification providers shall conform to all general certification standards and procedures at 8.487. HCBS-EBD Provider agencies.

2. Environmental modification providers shall be licensed in the city or county in which they propose to provide environmental modification services.

3. All environmental modifications shall be provided in accordance with the Uniform Building Code as adopted by the State of Colorado and all local building codes.

4. All environmental modifications shall be inspected and approved by a qualified individual such as:

- A local county building inspector or

- A licensed engineer, architect, contractor or any other person as agreed upon by the State.

- In addition, copies of building permits and inspection reports shall be submitted to the case management agency, and all problems noted on inspections shall be corrected before the provider submits a claim for the environmental modification.

E. REIMBURSEMENT METHOD FOR ENVIRONMENTAL MODIFICATION SERVICES

Payment of environmental modification services shall be the lower of the billed charges or the prior authorized amount. The unit of reimbursement shall be one unit per service rendered. The date of service is considered to be the day of completion of me modification

8.516.10 INDEPENDENT LIVING SKILLS TRAINING

A. DEFINTIONS

1. Independent Living Skills Training and Development means services designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

2. Skills training may be provided in the client's residence, in the community or in a group living situation.

B. INCLUSIONS

1. Services may include assessment, training, and supervision or assistance to an individual with self care, medication supervision, task completion, communication skill building, interpersonal skill development, socialization, therapeutic recreation, sensory motor skills, mobility or community transportation training, reduction or elimination of maladaptive behaviors, problem solving skill development, benefits coordination, resource coordination, financial management, and household management.

2. All independent living skills training and development shall be documented in the plan of care.

3. Independent Living Skills trainers must be supervised on a monthly basis by a fully licensed or certified occupational therapist, registered nurse, physical therapist, or speech therapist who has experience in the field of brain injury rehabilitation.

C. PROVIDER CERTIFICATION STANDARDS

1. Providers shall be a health care professional with one year of experience in providing functionally based assessment and skills training of individuals with disabilities, or an individual with a bachelors degree and two years of similar experiences, or an individual with an AA degree in a social service or human relations area with 3 years of experience.

2. All skills trainers must receive monthly supervision from a licensed or certified health care provider as listed above. Supervision of independent living skills trainers shall not be billable as an additional expense to Medicaid but shall be absorbed by the provider as an overhead expense of business.

3. Providers shall develop and administer a training program to all skills trainers which focuses on the specific needs of individuals with brain injury and demonstrates the completion of a 24 hour training program prior to the delivering of services.

D. REIMBURSEMENT

1. All independent living skills training must be documented in the plan of care. Monthly treatment plans shall include the goals of the treatment plan, goals met or accomplished, and progress made toward accomplishment of ongoing goals. All plans are subject to review of the Brain Injury Program Coordinator.

2. Reimbursement shall be on an hourly basis. Payment may include travel time to and from the client's residence, to be billed under the same procedure code and rate as independent living services. The time billed for travel shall be listed separately from the time for service provision on each visit but must be documented on the same form. Travel time must be summed for the week and then rounded to the nearest hour for billing purposes. If the travel time to and from a client's residence is 15 minutes one-way, 30 minutes round trip, then the travel time for one week shall be 210 minute (rounded up to 4 hours) for the week. Travel time to one client's residence may not also be billed as travel time from another client's residence, as this would represent duplicate billing for the same time period.

8.516.20 NON-MEDICAL TRANSPORTATION

A. DEFINITIONS

1. Non-medical transportation services means services as defined in 8.494.10.

2. Non-medical transportation provider means providers as defined in 8.494.10.

B. INCLUSIONS

Non-medical transportation services shall include, hut not be limited to transportation between the client's home and non-medical services or resources such as adult day care, shopping, therapeutic swimming, dentist appointments, counseling sessions, and other services as required by the care plan to prevent institutionalization.

C. EXCLUSIONS

1. Non medical transportation services shall not he used to substitute for medical transportation which is subject to reimbursement under Section 8.680 through 8.691. OTHER HEALTH SERVICES-TRANSPORTATION.

2. Non medical transportation services shall only he used after the case manager has determined that free transportation is not available to the client.

D. CERTIFICATION STANDARDS FOR TRANSPORTATION SERVICES

Transportation providers shall conform to all standards listed in 8.494.40 CERTIFICATION STANDARDS FOR TRANSPORTATION SERVICES.

8.516.30 TRANSITIONAL LIVING

A. DEFINITIONS

1. Transitional living means programs, which occur outside of the client's residence, designed to improve the client's ability to live in the community by provision of 24 hour services, support and supervision.

2. Program services include but are not limited to assessment, training. and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household. Programs are normally limited in duration to six months.

B. INCLUSIONS

1. All services must be documented in an approved plan of care and be prior authorized by the State Brain Injury Program Coordinator or designated agent.

2. Clients must need available assistance in a milieu setting for safety and supervision and require support in meeting psychosocial needs.

3. Clients must require available paraprofessional nursing assistance on a 24 hour basis due to dependence in activities of daily living, locomotion, or cognition.

4. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this level of care. If a client requires extraordinary

therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for high intensity therapy for a client must be documented and authorized individually through the Brain Injury Program Coordinator. "Extraordinary therapy needs" for purposes of this program, are defined by a client who needs more than three hours per week of any one therapeutic discipline: ie. physical therapy, occupational therapy, or speech therapy.

C. EXCLUSIONS

1. Transportation between therapeutic tasks in the community, recreational outings, and activities of daily living is included in the per diem reimbursement rate and shall not be billed as separate charges.

2. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.

3. Room and board charges are not a billable component of transitional living services.

4. Items of personal need or comfort shall be paid out of money set aside from client's, income, and accounted for in the determination of financial eligibility for the HCBS-BI program.

5. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the State Brain Injury Program Coordinator.

D. CERTIFICATION STANDARDS

Transitional living programs shall meet all standards established to operate as an Assisted Living Residence according to C.R.S. 25-1-107, et, seq.,

1. The Department of Public Health and Environment shall survey and license the physical facility of Transitional Living Programs.

2. Transitional living programs shall adhere to all additional programmatic, and policy requirements listed in SECTIONS following titled POLICIES, TRAINING, DOCUMENTATION, and HUMAN RIGHTS.

3. The Department of Health Care Policy and Financing shall review and provide certification of programmatic, standards.

4. If the program holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for the specific program for which they are seeking state certification, on-site review for initial certification may be waived. However, on-site reviews of all programs shall occur on at least a yearly basis.

5. The building shall meet all local and state fire and safety codes.

E. POLICIES

1. Clients must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.

2. The person must be medically stable as defined by having the need for less than one hour per eight hour shift of skilled nursing intervention and being able to actively participate in

intensive therapy during the day.

3. Clients, families, medical proxies,: or other substitute decision makers shall be made aware of accepting the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.

4. Understanding that clients of transitional living programs frequently experience behavior which may be a danger to themselves or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The transitional living program must have written agreements with other providers, in the community who may provide short term crisis intervention to provide a safe and secure environment for a client who is experiencing severe, behavioral difficulties, or who is actively homicidal or suicidal.

5. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve clients for whom they lack adequate resources to ensure safety of program participants and staff.

6. Upon entry into the program, discharge planning shall begin with the client and family. Transitional living programs shall work with the client and case manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living services.

7. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.

8. During daytime hours, the ratio of staff to clients shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.

9. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Brain Injury Program Coordinator.

F. TRAINING

1. At a minimum, the program director shall have an advanced degree in a health or human service related profession plus three years experience providing direct services to individuals with brain injury. A bachelor's degree with five years experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.

2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the client. These staff members will have successfully completed a training program of at least 40 hours duration.

3. Facility operators must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the facility.

4. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in first aid universal precautions, emergency procedures, and at least one staff

per shift shall be certified as a medication aide prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities.

G. DOCUMENTATION

1. Intake information shall include a completed neuropsychological assessment, all pertinent medical documentation from impatient and outpatient therapy and a detailed social history' to identify key treatment components and the functional implication of treatment goals.

2. Initial treatment plan development and evaluations will occur within a two week period following admission.

3. Goals and objectives reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.

4. Specific treatment modalities outlined in the treatment plan are systematically implemented with techniques that are consistent functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and will be reviewed and modified as appropriate.

5. Behavioral programs shall contain specific guidelines on treatment parameters and methods.

6. All transitional services must utilize licensed psychologists win two years experience in brain injury services for the oversight of treatment plan development, implementation and revision. There shall be regular contact and meetings with the client and family. Meetings shall include written recommendations and referral suggestions, as well as information on how the family will transition and incorporate treatment modalities into the home environment.

7. Programs shall have a process verified in writing by which a client is made aware of the process for filing a grievance. Complaints by the client or family shall be handled via telephone or direct contact with the client or family.

8. Customer satisfaction surveys will be regularly performed and reviewed.

9. Records must be signed and dated by individuals providing the intervention. Daily progress notes shall be kept for each treatment modality rendered.

10. Client safety in the community will be assessed: safety status and recommendations will be documented.

11. Progress towards the accomplishment of goals is monitored and reported in objective measurable terms on a weekly basis, with formal progress notes submitted to the case manager on a monthly basis.

H. HUMAN RIGHTS

All people receiving HCBS-BI transitional living services have the following rights:

1. All Human Rights listed in 8.515.80 C. apply.

2. Every person has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, or censored by the personnel of the facility.

I. REIMBURSEMENT

Providers of Transitional Living shall agree to accept the per diem reimbursement negotiated with the Department of Health Care Policy and Financing and will not bill the client in excess of his/her SSI payment or $400 per month, whichever is less for room and board charges.

All transitional living services shall be prior authorized through submission to the Brain Injury Program Coordinator. A Medicaid Prior Authorization Request must be submitted with tentative goals and rationale of the need for intensive transitional living services.

Transitional living services which extend beyond six months duration, must be reauthorized with attached treatment plan justification and shall be submitted, if appropriate, through the reconsideration process established with the Departmental fiscal agent.

8.516.40 BEHAVIORAL PROGRAMMING

A. DEFINITION

Behavioral programming and education is an individually developed intervention designed to decrease/control the client's severe maladaptive behaviors which, if not modified, will interfere with the individuals ability to remain integrated in the community.

B. INCLUSIONS

1. Programs should consist of a comprehensive assessment of behaviors, development of a structured behavioral intervention plan, and ongoing training of family and caregivers for feedback about plan effectiveness and revision. Consultation with other providers may be necessary to ensure comprehensive application of the program in all facets of the person's environment.

2. Behavioral programs may be provided in the community or in the client's residence unless the residence is a transitional living center which provides behavioral intervention as a treatment component

3. All behavioral programming must be documented in the plan of care and reauthorized after 30 units of service with the Brain Injury Program Coordinator.

C. CERTIFICATION STANDARDS

1. The program should have as its director a Licensed Psychologist who has one year of experience in providing neurobehavioral services or services to persons with brain injury or a health care professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist, Speech Language Pathologist, Registered Nurse or Masters level Psychologist with three years of experience in caring for persons with neurobehavioral difficulties. Behavioral specialists who directly

implement the program shall have two years of related experience in the implementation of behavioral management concepts.

2. Behavioral specialists will complete a 24-hour training program dealing with unique aspects of caring for and working with individuals with brain injury if their work experience does not include at least one year of same.

D. REIMBURSEMENT

Behavioral programming must be documented on the client's care plan and prior authorized through the State Brain Injury Program Coordinator. Behavioral programming services will be paid on an hourly basis as established by the Department

8.516.50 COUNSELING

A. DEFINITIONS

Counseling services mean individualized services designed to assist the participants and their support systems to more effectively manage and overcome the difficulties and stresses confronted by people with brain injuries.

B. INCLUSIONS

1. Counseling is available to the program participant's family in conjunction with the client if they: a) have a significant role in supporting the client or b) live with or provide care to the client. "Family" includes a parent, spouse, child, relative, foster family, in-laws or other person who may have significant ongoing interaction with the waiver participant.

2. Services may be provided in the waiver participant's residence, in community settings, or in the provider's office.

3. Intervention may be provided in either a group or individual setting: however, charges for group and individual therapy shall reflect differences.

4. All counseling services must be documented in the plan of care and must be provided by individuals or agencies approved as providers of waiver services by the Department of Health Care Policy and Financing as directed by certification standards listed below.

5. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as may be necessary to safely maintain the individual at home.

6. Prior authorization is required after thirty visits of individual, group, family or combination of modalities have been provided. Re-authorization is submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

1. Family training is not available to individuals who are employed to care for the recipient.

2. Family training/counseling must be carried out in the presence of and for the direct benefit of the client of the HCBS-BI program.

D. CERTIFICATION STANDARDS

1. Professionals providing counseling services must hold the appropriate license or certification for their discipline according to stale law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker. Certified Rehabilitation Counselor. Licensed Professional Counselor, or Licensed Clinical Psychologist.

2. All professionals applying as providers of counseling services must demonstrate or document a minimum of two years experience in providing counseling to individuals with brain injury and their families.

3. Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling (if the individual is present) Individual Counseling, and Group Counseling.

8.516.60 SUBSTANCE ABUSE COUNSELING

A. DEFINITION

Substance abuse programs are individually designed interventions to red ace or eliminate the use of alcohol and/or drugs by the water participant which. if not effectively dealt with, may interfere with the individual's ability to remain integrated in the community.

B. INCLUSIONS

1. Only outpatient individual, group, and family counseling services are available through the brain injury waiver program

2. Substance abuse services are provided in a non-residential setting and must include assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver participant, family or caregivers when appropriate, periodic reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, family counseling for persons if directly involved in the support system of the client, interdisciplinary care coordination meetings, and an aftercare plan staffed with the case manager.

3. Prior authorization is required after thirty visits have been provided of individual, group, or family counseling or a combination of modalities. Re-authorization requests shall he submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

Inpatient treatment is not a covered benefit.

D. CERTIFICATION STANDARDS

1. Substance abuse services may be provided by any agency or individual licensed or certified by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services and jointly certified by ADAD and the Department of Health Care Policy and Financing.

2. Programs must demonstrate a fully developed plan entailing the method by which coordination

will occur with existing community agencies and support programs to provide ongoing support to individuals with substance abuse problems. The program should promote training to improve the ability of the community resources to provide ongoing supports to individuals with brain injury.

3. Counselors should be certified at the Certified Alcohol Counselor III level or a doctoral level psychologist with the same level of experience in substance abuse counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any individual with a brain injury or their family members. A recommended training curriculum will include a three day session combining didactic and experiential components. A test will be administered by the ADAD and the resulting certification shall be valid for a period of two years.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling (if the individual is present). Individual Counseling, and Group Counseling.

8.518 CONSUMER DIRECTED CARE FOR THE ELDERLY

8.518.1 DEFINITIONS

Authorized Representative means an individual designated by the eligible person, or by the guardian of the eligible person, if appropriate, who has the judgment and ability to assist the eligible person in acquiring and utilizing services under the Home and Community Based Services-Consumer Directed Care for the Elderly program (HCBS-CDCE).

Care Plan shall be as defined at 10 C.C.R. 2505-10, Section 8.390.1(C), including the funding source, frequency, amount and provider of each service. This Care Plan shall be written on a Department-prescribed Long Term Care Plan form.

Case Management shall be as defined at 10 C.C.R. 2505-10, Section 8.390.1(D).

Case Manager means an individual employed by the Single Entry Point (SEP) agency who determines functional eligibility and provides Case Management services to clients eligible under HCBS-CDCE.

Financial Management Services organization (FMS) means the entity or entities under contract with the Department to provide personnel, fiscal management services and skills training to a client receiving Personal Support Services and/or his or her Authorized Representative.

Individual Allocation means the funds made available by the Department to clients receiving Personal Support Services and administered by the FMS. These funds shall be available each month that a client meets program eligibility, and they shall be calculated based on the client's utilization history of personal care and homemaker services or the personal care and homemaker services defined in the client's Care Plan.

Personal Support Attendant means the individual who provides Personal Support Services.

Personal Support Management Training means the required training, including a final, comprehensive test provided by the Department or its designee to a HCBS-CDCE client and/or his or her Authorized Representative who is interested in directing Personal Support Services.

Personal Support Services means supportive services which are essential to the health and welfare of the client and include personal care services as defined at 10 C.C.R. 2505-10, Section 8.489 and homemaker

services as defined at 10 C.C.R. 2505-10, Section 8.490 and are directed by the client and/or his or her Authorized Representative.

8.518.2 PARTICIPATION/AVAILABILITY

8.518.2.A. During the first year of implementation, HCBS-CDCE shall be available to clients residing in the counties that are served by the Longterm Care Options, Mesa County Department of Human Services and San Juan Basin Health Department Single Entry Point Agencies (SEPs).

8.518.2.B. In subsequent years, HCBS-CDCE shall be available to clients residing in the counties served by the remaining SEPs.

8.518.3 CLIENT ELIGIBILITY

8.518.3.A. To be eligible for HCBS-CDCE, a client shall:

1. Be 55 years or older.

2. Be willing to participate in the program.

3. Be eligible for HCBS-EBD as defined at 10 C.C.R. 2505-10, 8.485.60 et seq.

8.518.3.B. A client who wants to direct Personal Support Services shall:

1. Provide a statement from his or her primary care physician that indicates the client has sound judgment and the ability to direct his or her care or has an Authorized Representative who has the ability to direct the care on the client's behalf.

2. Demonstrate the ability to handle the financial aspects of self-directed care or has an Authorized Representative who is able to handle the financial aspects of the client's care.

3. Complete the Personal Support Management Training and pass the post-training test.

8.518.4 WAITING LIST PROTOCOL

8.518.4.A. Clients shall be enrolled in HCBS-CDCE within the capacity limits of the federal waiver based in ranking order on the following priorities:

1. Clients who receive long term home health benefits who could be served at a lesser cost to Medicaid.

2. Clients being deinstitutionalized from nursing facilities.

3. Clients being discharged from a hospital who, absent HCBS-CDCE services, would be discharged to a nursing facility at greater cost to Medicaid.

4. Clients with high Universal Long Term Care (ULTC) 100.2 assessment scores as defined at 10 C.C.R. 2505-10, Section 8.458.60, who are at risk of immediate nursing facility placement.

8.518.5 BENEFITS/SERVICES

8.518.5.A. The following benefits are available to HCBS-CDCE clients.

1. Adult day services as defined under HCBS-Elderly Blind and Disabled (EBD) at 10 C.C.R

2505-10, Section 8.491.

2. Alternative care facility services as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.495.

3. Electronic monitoring as defined under HCBS-EBD at 10.C.C.R. 2505-10, Section 8.488.

4. Home modification as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.493.

5. Homemaker services as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.490.

6. Personal care as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.489

7. Personal Support Services.

8. Respite as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.492.

9. Non-medical transportation as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.494.

10. A client enrolled in HCBC-CDCE shall not receive Home Care Allowance.

11. Personal care and homemaker services are not benefits if a client is receiving Personal Support Services.

8.518.6 PERSONAL SUPPORT MANAGEMENT PLAN

8.518.6.A. The HCBS-CDCE client and/or his or her Authorized Representative shall develop a written personal support management plan which shall be reviewed and approved by the case manager. The plan shall describe the following:

1. Client's current status.

2. Client's Personal Support Attendant needs.

3. Client's plans for securing Personal Support Services.

4. Client's plans for budgeting the Individual Allocation.

5. Client's plans for handling emergencies.

8.518.7 START DATE FOR SERVICES

8.518.7.A. The start date of eligibility for HCBS-CDCE services shall not occur until all of the requirements defined at 10 C.C.R. 2505-10, Section 8.485.60 have been met.

8.518.7.B. The Department or its designee shall approve the personal support management plan and establish a start date before a client can begin receiving Personal Support Services.

8.518.8 CLIENT AND AUTHORIZED REPRESENTATIVE RIGHTS AND RESPONSIBILTIIES

8.518.8.A. A client receiving or requesting Personal Support Services whose personal support management plan is disapproved by the Case Manager has the right to review that disapproval. The client shall submit a written request to the SEP stating the reasons for requesting the review and justifying the proposed management plan. The client's most recently approved personal

support management plan shall remain in effect while the review is in process.

8.518.8.B. Clients receiving Personal Support Services have the right to transition back to personal care and homemaker services provided by an agency at any time. A client who wishes to transition back to agency-provided services shall contact the Case Manager, who shall coordinate arrangements for the services.

8.518.8.C. A client and/or his or her Authorized Representative is responsible for cooperating in the determination of financial eligibility, including prompt reporting of changes in income or resources and cooperating with the SEP and services providers as agreed to in the client's Care Plan.

8.518.8.D. To receive Personal Support Services, each client and/or Authorized Representative shall sign a Participant/Authorized Representative Responsibilities Form acknowledging full responsibility for:

1. Completing training.

2. Developing a personal support management plan.

3. Budgeting for Personal Support Services within the established monthly allocation.

4. Recruiting, hiring, firing and managing Personal Support Attendants.

5. Completing reference checks on Personal Support Attendants.

6. Reviewing background checks on Personal Support Attendants.

7. Determining wages for Personal Support Attendants, within the range established by the FMS.

8. Establishing work schedules.

9. Training and supervising Personal Support Attendants.

10. Following all applicable laws and rules on employing Personal Support Attendants, with the exception of those set out at 10 C.C.R. 2505-10, Section 8.518.12(B), which are the responsibility of the FMS.

11. Completing and managing all paperwork.

8.518.9 CASE MANAGEMENT FUNCTIONS

8.518.9.A. SEP agencies shall comply with SEP rules governing Case Management functions as set forth at 10 C.C.R. 2505-10, 8.390 et seq. and shall comply with the following HCBS-CDCE specific requirements.

1. The Case Manager shall provide new and current clients with information on HCBS-CDCE.

2. The Case Manager shall complete screening and intake functions as defined at 10 C.C.R. 2505-10, 8.393.21 et seq.

3. The Case Manager shall complete the ULTC 100.2 assessment to determine nursing facility level of care as defined at 10 C.C.R. 2505-10, 8.390.22 et seq.

4. If a client is determined to be ineligible for HCBS-CDCE, the SEP shall notify the client and/or his or her Authorized Representative of the denial and the client's appeal rights as

defined at 10 C.C.R. 2505-10, Section 8.057.

5. The Case Manager shall develop the Care Plan after completing the client assessment and prior to the arrangement for services as defined at 10 C.C.R. 2505-10, Sections 8.390.1(C) and 8.486.51.

6. The Case Manager shall revise the Care Plan whenever a change in the client's needs results in an increase, decrease or other change in services. The Case Manager shall describe in detail reasons for the revision. When additional services include a service requiring a prior authorization request (PAR), the Case Manager shall submit the PAR to the Department's fiscal agent.

7. The Case Manager shall review and approve the personal support management plan completed by the client and/or his or her Authorized Representative. The Case Manager shall notify the client and/or his or her Authorized Representative of the approval and establish a start date.

8. If the Case Manager determines that the personal support management plan is inadequate to meet the client's personal support needs, the Case Manager shall assist the client and/or his or her Authorized Representative with further development of the personal support management plan.

9. The Case Manager shall calculate the initial Individual Allocation for each HCBS-CDCE client who chooses Personal Support Services as follows:

    a. Calculate an average monthly payment using prior utilization expenditures for personal care and homemaker services provided by the Department, or

    b. Calculate the number of personal care and homemaker hours needed on a monthly basis as defined on the Care Plan and multiply by the Department's established rate for personal care and homemaker services.

10. The Case Manager shall provide written notification of the Individual Allocation to each client.

11. A client and/or his or her Authorized Representative who believes that he or she needs more Personal Support Service than the existing Individual Allocation will cover, may request the Case Manager to perform a reassessment. If the reassessment indicates that more personal support is justified, the client and/or his Authorized Representative shall amend the personal support management plan and the Case Manager shall complete a Prior Authorization Request (PAR) revision indicating the increase and submit it to the Department's fiscal agent.

    a. In approving an increase in the Individual Allocation, the Case Manager shall consider:

        i) Any change in the client's condition.

        ii) Discrepancies between the client's utilization history and current needs for personal support.

        iii) The appropriateness of Personal Support Attendant wages.

        iv) The quality and quantity of services provided by Personal Support Attendants for the wages they receive.

        v) Revisions in the client's budgeting of the current Individual Allocation to more

effectively pay for needed services.

b. In reducing the Individual Allocation, the Case Manager shall consider:

i) Improvement or change in the condition.

ii) Reasons for unspent allocated funds.

12. The Case Manager shall notify the state fiscal agent to cease payment for all existing personal care and homemaker services as of the client's Personal Support Services start date.

13. The Case Manager shall monitor the services provided, as defined at 10 C.C.R. 2505-10, 8.393.43 et seq., to ensure that they are appropriate and effective, timely, safe and meet with the client's satisfaction.

14. For effective coordination, monitoring and evaluation of clients receiving Personal Support Services, the Case Manager shall:

a. Contact the client receiving Personal Support Services and/or the Authorized Representative twice a month during the first three months to assess their personal support management, their satisfaction with care providers and the quality of services received.

b. Contact the client quarterly, after the first three months to assess their implementation of service plans, personal support management issues, quality of care, personal support expenditures and general satisfaction.

c. Conduct a face-to-face visit with the client and/or his or her Authorized Representative when a change in the Authorized Representative occurs and contact the client and/or his or Authorized Representative twice a month for three months after this change takes place.

d. Review monthly reports to monitor client spending patterns and service utilization to ensure appropriate budgeting and follow up with the client and/or his or her Authorized Representative when discrepancies occur.

e. Contact the FMS quarterly to determine the status of each client's financial management activities.

15. Reassessment

a. The case manager shall complete a Reassessment of each client using the UTLC 100.2 assessment form before the end of the length of stay assigned at the last level of care determination for a continued stay review.

b. For clients receiving Personal Support Services, the Case Manager shall conduct a comprehensive face-to-face interview with each client and/or his or her Authorized Representative every six months. The interview shall include review of the personal support management plan and documentation from the physician that the client and/or his Authorized Representative has the ability to direct the care.

8.518.10 PRIOR AUTHORIZATION REQUEST

8.518.10.A. The Case Manager shall submit PARs to the Department according to the instructions given in the Medicaid Provider Bulletin published by the Department's fiscal agent.

8.518.10.B. The start date for a PAR shall not precede the HCBS-CDCE start date and shall not cover a period of time longer than the length of stay assigned by the SEP.

8.518.11 PROVIDER ENROLLMENT

8.518.11.A. Provider agencies shall meet requirements as defined under the HCBS-EBD program at 10 C.C.R. 2505-10, Sections 8.487.10 through 8.487.100.

8.518.12 PERSONAL SUPPORT ATTENDANTS

8.518.12.A. Personal Support Attendants shall be at least 16 years of age and demonstrate competency in caring for the client to the satisfaction of the client and/or his or her Authorized Representative.

8.518.12.B. The FMS shall be the employer of record for all Personal Support Attendants. The FMS shall be responsible for worker's compensation insurance, unemployment compensation insurance, withholding of all federal and state taxes, compliance with federal and state laws regarding overtime pay and minimum wage requirements and compliance with any other relevant federal, state or local laws.

8.518.13 REIMBURSEMENT

8.518.13.A. Provider agencies shall be reimbursed for services provided to eligible clients when claims are submitted in accordance with the following procedures:

1. Provider agencies shall submit claims to the fiscal agent on Department prescribed forms provided by the fiscal agent according to 10 C.C.R. 2505-10, Sections 8.040 and 8.043.

2. Provider agencies shall fill out claim forms adequately and correctly.

8.518.13.B. Provider agencies shall maintain adequate financial records for all claims, including documentation of services as specified at 10 C.C.R. 2505-10, Sections 8.040.02, 8.130 and 8.487.10.

8.518.13.C. When a client has been determined eligible for HCBS services under the 300% income standard, according to 10 C.C.R. 2505-10, Section 8.100, the Department may reduce Medicaid payment for Alternative Care Facility services according to the procedures at 10 C.C.R. 2505-10, Section 8.486.60.

8.518.13.D. Personal Support Attendants shall receive an hourly wage based on the rate negotiated between the Personal Support Attendant and the client and/or his or her Authorized Representative. The FMS shall make all payments from the client's Individual Allocation under the direction of the client and/or his or her Authorized Representative.

8.518.14 LIMITATIONS ON PAYMENT TO FAMILY [Perm Rule Change eff. 4/2/2007]

8.518.14.A. In no case shall any person be reimbursed to provide HCBS-CDCE services to his or her spouse.

8.518.14.B. Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under HCBS-CDCE, and/or be employed by the FMS to provide Personal Support Services, subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage,

adoption or common law.

1. The family member shall meet all requirements for employment by the following:

    a. A certified personal care agency and be employed and supervised by the personal care agency; and/or

    b. The FMS and be supervised by the client and/or his or her Authorized Representative if providing Personal Support Services.

2. The family member providing personal care shall be reimbursed at an hourly rate by the personal care agency and/or FMS which employs the family member, with the following restrictions:

    a. The maximum number of Medicaid personal care units per annual certification for HCBS-CDCE shall include any portions of the Medicaid reimbursement which are kept by the personal care agency and/or FMS for unemployment insurance, worker's compensation, FICA, cost of training and supervision and all other administrative costs.

3. If two or more HCBS-CDCE clients reside in the same household, family members may be reimbursed up to the maximum for each client if the services are not duplicative and are appropriate to meet the client's needs.

8.519 HOME AND COMMUNITY BASED SERVICES FOR CHILDREN WITH AUTISM WAIVER

8.519.1 DEFINITIONS

Assessment means a comprehensive face-to-face evaluation using the ULTC-100.2 conducted by the case manager with the client and appropriate collaterals, with supporting diagnostic information from the individual's medical professional(s), to determine the applicant's level of functioning, service needs, available resources and potential funding sources.

Autism means the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests as set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000. No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000 is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

Care Plan means the document used to identify the client's needs and sets forth the services to be provided to the client including the funding source, amount, scope, duration, frequency, provider of each service and the expected outcome or purpose of such services.

Case Management means the Assessment of a client's needs, the development and implementation of the Care Plan, coordination and monitoring of service delivery, the evaluation of service effectiveness and periodic reassessment of the client's needs.

Community Centered Board (CCB) means an agency contracted by the Department to conduct Assessments, develop the Care Plan and provide Case Management and Utilization Review.

Continued Stay Review (CSR) means a reassessment by the CCB case manager to determine the

client's continued eligibility and functional level of care.

Corrective Action Plan means a plan from the CCB written on a Department approved form that includes the actions the CCB shall take to correct non-compliance with regulatory standards and stipulates the date by which each action shall be completed.

Cost Containment means the determination that, on an individual client basis, the cost of providing care in the community is less than or the same as the cost of providing care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

Intake/Screening/Referral means the CCB's initial contact with an individual and shall include, but not be limited to, a determination of the need for a comprehensive client Assessment, referral to other waivers or services and long-term care services.

Lead Therapist means a qualified Medicaid provider who assesses the client's need for behavioral therapies and prescribes the treatment plan.

Line Staff means a qualified Medicaid provider who works directly with the client using behavioral therapies.

Senior Therapist means the qualified Medicaid provider who is responsible for training the Line Staff in proper application of prescribed therapies and providing on-going supervision and implementation of the treatment plan, including documentation of client progress.

Uniform Long Term Care 100.2 Form (ULTC 100.2) means the tool used to assess the functional needs of an applicant.

Utilization Review means approving or denying admission or continued stay in the waiver based on level of care need, clinical necessity, amount and scope, appropriateness, efficacy or efficiency of health care services, procedures or settings.

8.519.2 BENEFITS

8.519.2.A. Home and Community Based Services for Children with Autism (HCBS-CWA) benefits shall be provided within Cost Containment.

8.519.2.B. Behavioral therapies shall be provided in a group or individual setting.

8.519.2.C. Behavioral therapies may include:

1. Intensive developmental behavioral therapies developed specific to the client's needs including conditioning, biofeedback or reinforcement techniques.

2. Treatment goals that are consistent with building elementary verbal skills, teaching imitation, establishing appropriate toy play or interactive play

3. with other children, teaching appropriate expression of emotions and behaviors, and where necessary, reducing self stimulation and aggressive behaviors.

4. One on one behavior therapy conducted with the client and Line Staff, following a specific protocol established by the Lead Therapist.

5. Training or modeling for parents or a guardian so that the behavioral therapies can continue in the home. Training or modeling shall be:

a. Directed towards instruction on therapies and use of equipment specified in the Care Plan.

b. Carried out in the presence of and for the direct benefit of the client.

c. Conducted by the Line Staff.

8.519.2.D. Behavioral therapies shall only be a benefit if they are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

8.519.2.E. Benefits shall be limited to three years, either contiguous or intermittent with a one year extension based on medical necessity as stated by the client's physician and upon approval by the Department.

8.519.2.F. The annual cost of benefits per client shall not exceed $25,000 or available funds whichever is less.

8.519.3 NON-BENEFIT

8.519.3.A. Case Management shall not be a benefit of the HCBS-CWA waiver but shall be provided as an administrative activity through the CCB.

8.519.3.B. Speech therapy shall not be a benefit under behavior therapies.

8.519.4 CLIENT ELIGIBILITY

8.519.4.A. An eligible client shall:

1. Be determined financially eligible by the financial eligibility site in the county where the applicant resides.

2. Be determined to meet the Federal Social Security Administration definition of disability.

3. Be at risk of institutionalization into an ICF/MR as determined by the CCB case manager using the ULTC 100.2.

4. Meet the target population criteria as follows:

    a. Has a diagnosis of Autism as certified by a physician.

    b. Has not yet reached six years of age.

5. Be determined by the CCB case manager to be able to be safely served in the community within Cost Containment.

8.519.4.B. A client shall receive at least one HCBS-CWA waiver benefit per month to maintain enrollment in the waiver.

8.519.4.C. A client who has not received at least one benefit on the HCBS-CWA waiver for a period of one month shall be discontinued from the waiver.

8.519.4.D. Case Management shall not satisfy the requirement to receive at least one benefit per month on the HCBS-CWA waiver.

8.519.5 WAIT LIST

8.519.5.A. The number of clients who may be served through the waiver at any one time during a year shall be limited to 75.

8.519.5.B. Applicants who are determined eligible for benefits under the HCBS-CWA waiver, who cannot be served within the 75 client limit, shall be eligible for placement on a wait list maintained by the Department.

8.519.5.C. The CCB case manager shall ensure the applicant meets all criteria as set forth in Section 8.519.4 prior to notifying the Department to place the applicant on the wait list.

8.519.5.D. The CCB case manager shall notify the Department by entering the ULTC 100.2 Form and Professional Medical Information Page data in the Benefits Utilization System (BUS).

8.519.5.E. The date and time of notification from the CCB case manager shall be used to establish the order of an applicant's place on the wait list.

8.519.5.F. Within five working days of notification from the Department that an opening for the HCBS-CWA waiver is available the CCB shall:

1. Reassess the applicant for functional level of care using the ULTC 100.2 Form if the date of the last Assessment is more than six months old.

2. Update the existing ULTC 100.2 Form data if the date is less than six months old.

3. Reassess for the target population criteria.

4. Notify the Department of the applicant's eligibility status.

8.519.6 PROVIDER ELIGIBILITY

8.519.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CWA waiver, meet the responsibilities as set forth in Section 8.519.7 and enter into an agreement with the Department as set forth in 10 C.C.R. 2505-10, Section 8.130.

8.519.6.B. Providers shall enroll individually with the fiscal agent.

8.519.6.C. Providers shall be employed by a qualified Medicaid provider agency, clinic or hospital except for a Lead Therapist who may provide services independent from a Medicaid provider agency when the Lead Therapist employs the Senior Therapist and Line Staff.

8.519.6.D. Lead Therapists shall meet all of the following requirements:

1. Have a doctoral degree with a specialty in psychiatry, medicine or clinical psychology and be actively licensed by the state board of examiners.

2. Have completed 1,500 hours of training and/or have direct supervised experience delivering behavioral therapies consistent with best practice and research on the effectiveness for children with Autism.

3. Have two years of experience as a behavior therapist and/or has behavior therapist supervisory experience of at least one year.

8.519.6.E. The Lead Therapist shall prescribe the amount, scope and duration of the therapy, make treatment adjustments and be responsible for treatment outcomes.

8.519.6.F. Senior Therapists shall meet one of the following requirements:

1. Be a licensed psychotherapy provider with a master's degree in one of the behavior sciences and have completed 400 hours of direct supervised training in the use of behavioral therapies that are consistent with best practice and research on effectiveness for children with Autism.

2. Have a bachelor's degree in a human services field and have completed at least 2,000 hours of direct supervised training in the use of behavioral therapies that are consistent with best practice and research on effectiveness for children with Autism.

8.519.6.G. Line Staff shall meet all of the following requirements:

1. Be at least 18 years of age.

2. Have graduated from high school or have earned a high school equivalency degree.

3. Have 30 hours or more of direct supervised experience under the direction of a Lead or a Senior Therapist in the use of behavioral therapies that are consistent with best practice and research on effectiveness for children with Autism.

4. Be determined by the Lead Therapist to understand the specific services and outcomes for the child being served and for regularly reporting client activity to the Senior and Lead Therapists.

5. Have cleared the provider's background check at the time he/she is hired.

8.519.6.H. Line staff may be responsible for the delivery of the behavioral therapies to the client, if deemed appropriate by the Lead and Senior Therapists.

8.519.7 PROVIDER RESPONSIBLITIES

8.519.7.A. Lead Therapists not employed by a Medicaid provider agency, clinic or hospital shall have written policies and procedures regarding :

1. Recruiting, selecting, retaining and terminating employees.

2. Handling and reporting critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity pursuant to section 19-3-304 C.R.S. (2005). No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Colorado Revised Statues, copyright 2005 by the committee on legal services for the State of Colorado, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

   a. The Lead Therapist shall maintain a log of all complaints and critical incidents which shall include documentation of the resolution of the complaint or incident.

   b. The Lead Therapist shall communicate any critical incident via e-mail or fax to the Department within one business day.

8.519.7.B. Lead Therapists not employed by a Medicaid provider agency, clinic or hospital shall:

1. Ensure a client is not discontinued or refused services unless documented efforts have been

made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure that adequate records are maintained.

    a. Client records shall contain:

        i) Name, address, phone number and other identifying information on the client and the client's parent(s) and/or legal guardian.

        ii) Name, address and phone number of the CCB and the CCB case manager.

        iii) Name, address and phone number of the client's primary physician.

        iv) Special health needs or conditions of the client.

        v) Documentation of the specific services provided which includes:

            1) Name of the individual provider.

            2) The location for the delivery of services.

            3) Units of service.

            4) The date, month and year of services and, if applicable, the beginning and ending time of day.

        vi) Documentation of any changes in the client's condition or needs, as well as documentation of action taken as a result of the changes.

        vii) Documentation regarding supervision of benefits.

    b. Personnel records for each employee shall contain:

        i) Documentation of qualifications to provide behavioral therapies.

        ii) Documentation of training.

        iii) Documentation of supervision and performance evaluation.

        iv) Documentation that an employee was informed of all policies and procedures as set forth in Section 8.519.7.B.

        v) A copy of the employee's job description.

    c. Financial records for all claims, including documentation of services as set forth at 10 C.C. R. 2505-10, Section 8.040.02.

8.519.8 CCB ELIGIBILITY

8.519.8.A. A CCB shall enter into a contract with the Department to provide client Assessment, Case Management and Utilization Review.

8.519.8.B. The CCB shall have computer hardware and software, compatible with the Department's BUS, with capacity and capabilities as prescribed by the Department.

8.519.8.C. The CCB shall be certified annually in accordance with quality assurance standards and requirements set forth in 10 C.C.R. 2505-10, Section 8.079.2.

1. Certification of a CCB shall be based on a survey of each CCB's performance in the following areas:

    a. Quality of the Case Management services provided by the CCB to the clients based on the client satisfaction survey.

    b. Compliance with waiver requirements.

    c. Performance of administrative functions, including Cost Containment, timely reporting, on-site visits to clients, community outreach and client monitoring.

    d. Whether targeted populations are identified and served.

    e. Financial accountability .

    f. Retention of qualified personnel to perform the contracted duties.

2. The CCB shall receive denial, provisional approval or approval of certification based on the outcome of the certification survey.

3. In the event that the CCB does not meet the quality assurance standards, the CCB may receive provisional approval for certification for a period not to exceed 60 days provided the deficiencies do not constitute a threat to the health and safety of the clients.

    a. The CCB shall submit a Corrective Action Plan to address any deficiencies. Upon receipt and review of the Corrective Action Plan, provisional certification may be approved at the Department's discretion for a single additional 60 day period.

    b. If the Corrective Action Plan is not implemented successfully within the 60 day period, the service area will be assigned to another CCB.

    c. The CCB may receive technical assistance from the Department to facilitate corrective action.

8.519.8.D. The Department or its designee shall conduct reviews of the CCB agency.

8.519.9 CCB RESPONSIBILITIES

8.519.9.A. The CCB shall, in a format and manner specified by the Department, be responsible for the collection and reporting of summary and client specific data including, but not limited, to information and referral services provided by the agency, waiver eligibility determination, financial eligibility determination, care planning, service authorization, fiscal accountability and utilization review.

8.519.9.B. The CCB shall maintain case records in accordance with Department requirements.

1. Case records shall be maintained for:

    a. Individuals for whom the CCB completed an intake for HCBS-CWA.

    b. Individuals who are HCBS-CWA clients.

2. Case records shall contain:

    a. Identifying information, including the client's Medicaid identification number and social security number.

    b. A copy of the ULTC 100.2 Form and the Professional Medical Information Page (PMIP).

    c. Documentation of the date on which the client referral was first received and dates of all actions taken thereafter by the CCB.

    d. Documentation of all Assessment and target population criteria outcomes.

    e. Documentation of all Case Management activities, the monitoring of service delivery, and service effectiveness.

    f. Identifying information referencing the client's parent(s) and/or legal guardian.

    g. Documentation that all Department required forms have the required signatures .

3. The CCB shall protect the confidentiality of all applicants and recipient records in accordance with section 26-1-114, C.R.S. (2005). No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Colorado Revised Statues, copyright 2005 by the committee on legal services for the State of Colorado, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

4. The CCB shall protect the confidentiality of all applicants and recipient records in accordance with and the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 C.F.R., Parts 160 and 164. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the federal privacy law, copyright 1996, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

5. The CCB shall obtain release of information forms from the client's parent(s) and/or legal guardian which shall be signed, dated and renewed at least annually or when there is a change in benefit provider.

8.519.9.C. The CCB shall assure that each client's parent(s) and/or legal guardian:

1. Is fully informed of his/her rights and responsibilities.

2. Participates in the development and approval of the Care Plan and is provided a completed copy.

3. Is given a choice of service providers from qualified providers in the CCB district of his/her residence.

4. Is fully informed of and given access to a uniform complaint system as defined by the Department.

8.519.9.D. At least annually, the CCB shall conduct a client satisfaction survey which consists of surveying a sample of clients selected by the Department to determine their level of satisfaction

with services provided by the CCB.

1. The random sample of clients shall include ten clients or ten percent of the CCB's average monthly HCBS-CWA caseload, whichever is higher.

2. If the CCB's average monthly HCBS-CWA caseload is less than ten clients, all clients shall be included in the survey.

3. The client satisfaction survey shall be on a Department approved form.

4. The results of the client satisfaction survey shall be made available to the Department.

8.519.9.E. The CCB shall not require clients to come to the agency's office to receive Assessments, Utilization Review services or Case Management services.

8.519.9.F. The CCB shall provide adequate staff to meet all service and administrative functions.

1. The CCB shall have a system for recruiting, hiring, evaluating, and terminating employees that complies with all federal and state affirmative action and civil rights requirements.

2. The CCB shall employ at least one full time case manager.

3. The CCB shall have adequate support staff to maintain a computerized information system in accordance with the Department's requirements.

4. The supervisor and case manager shall meet minimum the following standards for education and/or experience:

    a. The case manager shall have at least a bachelor's degree in one of the human behavioral science fields or nursing.

    b. The supervisor shall meet all qualifications for a case manager and have a minimum of two years of experience in long term care.

    c. The CCB may request a waiver of these requirements from the Department prior to employing an individual when the CCB has been unable to secure the services of a qualified individual. The waiver shall be granted approval at the discretion of the Department.

5. CCB staff shall attend training sessions as directed and/or provided by the Department at Departmental cost.

6. The CCB shall provide in-service and staff development training at the CCB cost.

8.519.9.G. CCB SERVICE FUNCTIONS

1. The CCB shall complete the following activities as a part of its Intake/Screening/Referral function:

    a. Evaluate inquiries and address accordingly.

    b. Determine the appropriateness of a referral for an Assessment.

    c. Provide information and referral to other agencies as needed.

d. Initiate the ULTC 100.2 Form within two working days of receiving a referral.

e. Identify potential payment source(s), including the availability of private funding resources.

f. Verify the applicant's financial eligibility status for Medicaid, or refer the applicant to the financial eligibility site in the applicant's county of residence to determine financial eligibility for Medicaid.

g. Notify the applicant's parent(s) and/or legal guardian of his/her right to appeal adverse actions of the CCB, the Department, or contractors acting on behalf of the Department as set forth in 10 C.C.R. 2505-10, Section 8.057.

h. Obtain the applicant's parent(s) and/or legal guardian's signature on the ULTC 100.2 Intake Form.

2. If a referral for HCBS-CWA waiver services is determined to be appropriate, the CCB shall complete the following activities as a part of its Assessment:

a. Obtain diagnostic information supplied from the Professional Medical Information Page from the applicant's medical provider, physician or nurse.

b. Determine the applicant's functional capacity during an Assessment, through observation of the applicant and family in his/her residential setting.

c. Determine the applicant's service needs, taking into consideration services available or already being received from all funding sources.

d. Inform the applicant's parent(s) and/or legal guardian of the right to choose enrollment in other HCBS waivers for which the applicant is qualified. Document on the Care Plan, the parent(s) and/or legal guardian's waiver selection preference.

e. Maintain appropriate documentation for certification of waiver eligibility.

f. Submit documentation, as determined by the Department, for authorization of services.

3. The CCB shall complete the following activities as a part of the Utilization Review function:

a. Log each ULTC 100 .2 Form received and reviewed.

b. Score the ULTC 100.2 Form within one business day from the date of the CCB case manager's Assessment.

c. Input an electronic copy of the ULTC 100.2 Form on the BUS within 10 business days after completing the Assessment.

d. Notify the applicant's parent(s) and/or legal guardian of the outcome of the ULTC 100.2 Assessment and the Notice of Services Status (LTC 803) Form.

i) The Assessment outcome shall be based upon waiver requirements and the ULTC 100.2 functional needs assessment score and shall determine if a client is approved or denied for enrollment or continued stay in the waiver.

ii) When the Assessment outcome is a denial for enrollment in the waiver, the

CCB shall notify the applicant's parent(s) and/or legal guarding in accordance with 10 C.C. R. 2505-10, Section 8.057.

4. The CCB shall develop the Care Plan upon completion of the ULTC 100.2 functional needs assessment and prior to authorizing services. The CCB shall complete the Care Plan and all required paperwork within 15 business days upon eligibility determination. Care planning shall include, but not be limited to:

    a. Identifying and documenting Care Plan goals made with client's parent(s) and/or legal guardian's participation.

    b. Identifying and documenting services needed including the type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but not available.

    c. Documenting a client's parent(s) and/or legal guardian's selection of qualified providers.

5. The CCB shall be financially responsible for any services authorized which do not meet the requirements as set forth in Section 8.519 et. seq., or which are rendered by a provider due to the CCB's failure to timely notify the provider that the client is no longer eligible for services.

6. The CCB shall provide on-going Case Management for a client as defined below:

    a. On-going Case Management shall include, but not be limited to:

        i) Review the Care Plan.

        ii) Contact the client's parent(s) and/or legal guardian concerning the satisfaction with services provided.

        iii) Contact the service providers concerning their effectiveness and appropriateness regarding their service coordination.

        iv) Investigate complaints raised by the client's parent(s) and/or legal guardian concerning the service providers.

        v) Contact the appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client's parent(s) and/or legal guardian.

        vi) Resolve conflict or crisis related to the waiver benefit or Medicaid state plan service delivery, as needed.

        vii) Assess changes in the client's functioning, service effectiveness, service appropriateness and service cost-effectiveness.

        viii) Refer to community resources as needed.

    b. The CCB shall contact the client's parent(s) and/or legal guardian at least monthly or more frequently as determined by the client's needs.

    c. The CCB shall review and update the ULTC 100.2 Form and Care Plan, with the client's parent(s) and/or legal guardian annually or as required by a significant

change in the client's condition. The review shall be conducted by telephone or at the client's place of residence, place of service or other appropriate setting as determined by the client's needs.

d. The CCB shall contact the service providers to monitor service delivery at least every three months, as required by the client's needs or the specific service requirements.

e. If the CCB suspects a client to be a victim of abuse, neglect or exploitation, the CCB shall immediately refer the client to the protective services section of the county department of social services in the client's county or residence and/or the local law enforcement agency.

f. The CCB shall immediately report any information that indicates an overpayment, incorrect payment or misuse of any public assistance benefit to the Department. The CCB and case manager shall cooperate with the appropriate agency in any subsequent recovery process in accordance with the 10 C.C.R. 2505-10, Section 8.076.

7. The CCB shall complete a CSR of a client within 12 months of the initial ULTC 100.2 Assessment or the previous CSR. The CSR shall be completed at least one, but not more than three months before the end of the current certification period. A CSR shall be completed sooner if the client's condition changes.

   a. A CSR shall include but not be limited to the following activities:

      i) Obtain an update of the Professional Medical Information Page from the client's physician.

      ii) Assess a client's functional status face-to-face at the client's place of residence using the ULTC 100.2 Form.

      iii) Update the Care Plan and provider contacts.

      iv) Evaluate service effectiveness, quality of care and appropriateness of services.

      v) Verify continuing Medicaid financial and waiver eligibility.

      vi) Inform the client's Lead Therapist of any changes in the client's needs.

      vii) Refer the client to community resources as needed and develop resources for the client to the extent that the resource can be made available in the community.

      viii) Submit the appropriate Department approved form for authorization of services.

8. The CCB shall notify the client's parent(s) and/or legal guardian within one working day of determining the client no longer meets waiver requirements.

   a. A client shall be notified of the denial/discontinuation by the CCB on the Department prescribed LTC 803 form if he/she is determined ineligible due to any of the following reasons:

i) The client no longer meets all of the criteria set forth at Sections 8.519.4.A and 8.519.4.B.

ii) The client exceeds the limitations set forth at Sections 8.519.2.E and 8.519.2.F.

iii) The client's parent(s) and/or legal guardian has twice in a 30 day consecutive period, refused to schedule an appointment for an Assessment or Case Management visit.

iv) The client's parent(s) and/or legal guardian has failed to keep three scheduled provider appointments in a 30 day period.

v) The client's parent(s) and/or legal guardian fails to sign the Intake, Care Plan, Release of Information, or other forms as required.

b. The CCB shall notify a client's parent(s) and/or legal guardian of the denial or discontinuation of services using the Department prescribed advisement letter for reasons not related to enrollment criteria:

i) A client who moves out of Colorado shall be discontinued effective upon the day after the date of the move.

ii) A client whose parent(s) and/or legal guardian voluntarily withdraws the client from the waiver shall be discontinued effective upon the day after the date on which the request is documented, or the date on which the client enters a long term care institution or another HCBS waiver.

c. The CCB shall not send notification when the denial or discontinuation is due to the death of the client. A client who dies shall be discontinued from the waiver, effective upon the day after the date of death.

d. The case manager shall provide the client with appropriate referrals to other community resources, as needed, within one working day of discontinuation.

e. The CCB shall notify all providers on the Care Plan within one working day of discontinuation.

f. The CCB shall notify the financial eligibility site within one working day after the denial or discontinuation.

g. If a case is discontinued before an approved HCBS prior authorization request (PAR) has expired, the case manager shall submit to the Department, within five working days of discontinuation, a copy of the current PAR form on which the end date is adjusted and highlighted. The reason for discontinuation shall be noted on the form.

9. The CCB shall participate in the appeals process per 10 C.C.R. 2505-10, Section 8.057 et seq.

a. The CCB shall provide information to an applicant's parent(s) and/or legal guardian regarding appeal rights when he/she applies for the waiver or whenever such information is requested, whether or not an adverse action has been taken by the CCB.

b. The CCB shall attend an appeals hearing to defend a determination of enrollment, denial or discontinuation .

c. The CCB shall not attend an appeal hearing for a denial or discontinuation based on financial eligibility unless subpoenaed or requested by the Department.

8.519.10 PRIOR AUTHORIZATION REQUESTS

8.519.10.A. The CCB shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CWA waiver.

1. All units of service requested shall be listed on the Care Plan form.

2. The first date for which services can be authorized shall be the later of any of the following:

   a. The financial eligibility start date, as determined by the financial eligibility site.

   b. The assigned start date on the certification page of the ULTC 100.2 Form.

   c. The date, on which the client's parent(s) and/or legal guardian signs the Care Plan form or Intake form, as prescribed by the Department, agreeing to receive services.

3. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the ULTC 100.2 Form.

4. The CCB shall submit a revised PAR if a change in the Care Plan results in a change in services.

   a. The revised Care Plan shall list the services being changed and state the reason for the change. Services on the revised Care Plan form, plus all services on the original Care Plan, shall be entered on the revised PAR.

   b. Revisions to the Care Plan requested by providers after the end date on a PAR shall be disapproved.

5. A revised PAR shall not be submitted if services on the Care Plan are decreased, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.

6. If services are decreased without the client's parent(s) and/or legal guardian agreement, the case manager shall notify the client's parent(s) and/or legal guardian of the adverse action and of appeal rights using the LTC 803 form in accordance with the 10 day advance notice period.

8.519.11 REIMBURSEMENT

8.519.11.A. Reimbursement for CCB functions shall be determined by the number of clients served and the type of services provided and is subject to the availability of funds.

8.519.11.B. Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee schedule as determined by the Department.

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

Home Health services reimbursed by Medicaid shall be limited to skilled nursing services, home health aide services, occupational therapy services, physical therapy services, and speech/language pathology services, as defined at Section 8.525, SERVICES REQUIREMENTS.

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 faculties 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.

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.

8.524 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 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.

.13 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.

.14 STATE

State means the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

8.525 SERVICES REQUIREMENTS

.10 NURSING SERVICES

A. Nursing services include those skilled nursing services that are provided by a registered nurse under applicable state and federal laws, and professional standards.

B. Nursing services also includes skilled nursing services which are provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws.

.11 HOME HEALTH AIDE SERVICES

A. Home health aide services may be provided when a nurse or therapist determines that an eligible client requires the services of a qualified home health aide, as such services are defined in this section.

B. Home health aide services must be supervised according to Medicare Conditions of Participation for Home Health Agencies found at 42 CFR 84.36 (d). No later amendments to or editions of 42 CFR 484.36 (d) are included. Copies of 42 CFR 484.36 (d) are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

1. If the client receiving home health aide services also requires and receives skilled

nursing care or physical, occupational or speech therapy, the supervising registered nurse or therapist must make on-site supervisory visits to the client's home no less frequently than every two weeks.

2. If the client receiving home health aide services does not require skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse must make on-site supervisory visits to the client's home no less frequently than every 62 days. Each supervisory visit must occur while the home health aide is providing care. Visits by the registered nurse to supervise and to reassess the care plan are considered costs of providing the home health aide services, and shall not be billed to Medicaid as nursing visits.

3. Registered nurses and physical, occupational and speech therapists supervising home health aides must comply with applicable State laws governing their respective professions. In addition, the Nurse Aide Practice Act at § 12-38.1-102(5) C.R.S. (1998), which requires supervision of the practice of nurse aide services, must be followed. No later amendments to or editions of § 12-38.2-102(5) C.R.S. (1998) are included. Copies of § 12-38.1-102(5) C.R.S. (1998) are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street. Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

C. Before providing any services, all home, health aides shall be trained and certified according to Federal Medicare regulations at 42 CFR 484.36 and all applicable. State and Federal laws and regulations governing nurse, aide certification, as amended, except that later amendments to or editions of 42 CFR 484.36 shall not be included in this rule. Copies, of 42 CFR 484.36 are available for public inspection or will be provided at cost upon request by the Home Health Program Administrator, at the. Colorado. Department of Health Care Policy and Financing, 1575 Shaman Street, Denver, Colorado 80203-1714; or may be examined at any state, publications depository library.

D. Home, health aide services include, skilled personal care, unskilled personal care, and homemaking as defined below:

1. Skilled personal care includes nurse aide tasks performed by a certified. nurse aide pursuant to the nurse aide scope of practice defined by the State Board of Nursing, but does not include those tasks that are allowed as unskilled personal care, in HCBS personal care regulations at Section 8.489, PERSONAL CARE.

2. Unskilled personal care means those tasks which are allowed as unskilled personal care at Section 8.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE. Unskilled care shall be provided only as secondary to required skilled personal care, provided within contiguous units of service.

3. Homemaking includes those tasks that are allowed as homemaking tasks at Section 8.490, HOME AND COMMUNITY BASED SERVICES. - EBD, HOMEMAKER SERVICES. Homemaking services shall be provided only as secondary to required skilled personal care provided within contiguous units of service.

4. Home health aide services solely for the purpose of behavior management are not a benefit under Medicaid Home Health, because behavior management is outside the nurse aide scope of practice.

.12 PHYSICAL THERAPY SERVICES

A. Physical therapy includes any evaluations and treatments allowed under state law at 12-41-101 through 130, C.R.S. (1991, as amended), which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request and shall assist in training or the use of the equipment.

C. Treatment must be provided by or under the supervision of a licensed physical therapist who meets the qualifications prescribed by federal regulation for participation under Medicare, at 42 CFR 484.4; and who meets all requirements under state law. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or will be provided at cost upon request by the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care, the physical therapist may open be case and establish the Medicaid plan of care.

E. Effective September 1, 2002, physical therapy services are available for Acute Home Health clients when medically necessary and clients under 18 years of age when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

.13 OCCUPATIONAL THERAPY SERVICES

A. Occupational therapy includes any evaluations and treatments allowed under the standards of practice authorized by the American Occupational Therapy Association, which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request and shall assist in training on the use of the equipment.

C. Treatment must be provided by or under the supervision of a certified occupational therapist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or ml be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care or physical or speech therapy, the occupational therapist may open the case and establish the Medicaid plan of care.

E. Effective September 1, 2002, occupational therapy services are available for Acute Home Health clients when medically necessary and for clients under 18 when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at

8.201.A.

.14 SPEECH/LANGUAGE PATHOLOGY SERVICES

A. Speech/language pathology services include any evaluations and treatments allowed under the American Speech-Language-Hearing Association (ASHA) authorized scope of practice statement, which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through 8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.

C. Treatment must be provided by a speech/language pathologist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or will be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care, the speech therapist may open the case and establish the Medicaid plan of care.

E. Effective September 1, 2002; speech/language pathology services are available for Acute Home Health, clients when medically necessary and for clients under 18 when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201A.

8.526 PROVIDER AGENCY REQUIREMENTS

.10 A Home Health agency must be a public agency or private organization or part of such an agency or organization which:

A. Is certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act; and

B. Has a valid agreement with the State, according to Section 8.130, PROVIDER AGREEMENTS, of this manual, to provide Medicaid Home Health services, as defined above. The Medicaid agreement will cover only those services which are covered by the agency's Medicare certification; and

C. Maintains liability insurance for the minimum amount set annually by the Colorado Department of Health Care Policy and Financing.

.11 Home Health agencies which perform procedures in the client's home that are considered waivered clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 must possess a certificate of waiver from the Health Care Financing Administration or its designated agency.

.12 Home Health agencies must have written policies regarding nurse delegation.

.13 For all clients who are expected to need home health aide services for at least a year, the supervising nurse must, during supervisory visits:

A. Obtain the client's, or the-client's designated representative's, input into the home health aide assignment form, including all home health aide tasks to be performed during each scheduled time period. Details such as, but not limited to, housekeeping duties and standby assistance, must be negotiated and included on the home health aide assignment form so that all obligations and expectations are clear. The home health aide assignment form shall contain information regarding special functional limitations and needs, safety considerations, special diets, special equipment, and any other information that is pertinent to the care that will be given by the aide. The client or the client's designated representative must sign the form, and must be given a copy, at the beginning of services, and at least once per year thereafter. For purposes of complying with this rule, once per year shall be defined as sometime within the certification period which includes the anniversary date of the last signature on a home health aide assignment form.

B. Give each client, and/or the client's designated representative, a new copy of the Patient's Rights form, and explain those rights whenever the home health aide assignment form is renegotiated and rewritten.

.14 Home Health agencies shall obtain the official Medicaid rules, 10 CCR 2505-10 also known as Volume 8, and shall subscribe annually to the official updates. These rules shall be made available to all staff.

.15 Home Health agencies shall have written policies regarding maintenance of clients durable medical equipment, and shall make full disclosure of these policies to all clients with durable medical equipment in the home. The policies shall provide such disclosure to the client at the time of intake.

.16 Home Health agencies shall have written policies regarding procedures for communicating with case managers of clients who are also enrolled in HCBS programs. Such policies shall include, at a minimum, how agencies will inform case managers that services are being provided or are being changed; and procedures for sending copies of plans of care if requested by case managers. These policies shall be developed with input from case managers.

.17 Any Home Health Agency applying to become a Medicaid participating Home Health Agency shall submit an acceptable compliance plan as a condition of eligibility for entering into a Medicaid provider agreement in Colorado. The plan must demonstrate how the agency will assure compliance with Colorado Medicaid rules, and must demonstrate that the applicant agency knows and understands the rules.

18. A home health provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

19. A Home Health Agency may be denied or terminated from participation in Colorado Medicaid <u>independently of participation in Medicare</u> , according to procedures found at Section 8.050 through Section 8.051.44, based on good cause, as defined at 8.051.01. Good cause for denial or termination of a Home Health Agency shall include, but not be limited to, the following:

A. <u>Medicare Conditions Out of Compliance</u> . For purposes of this section, the applicable Medicare Conditions of Participation are found in 42 CFR 484, at 484.10,484.12,484.14, 484.16,484.18,484.30, 484.32,484.36,484.48, and 484.52. No later amendments to or editions of 42 CFR 484 are included. Copies of 42 CFR 484 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 or the material may be examined at any State Publications Depository Library.

1. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on the first re-certification survey after initial certification, or on a complaint investigation prior to the first re-certification survey.

2. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on two consecutive surveys and/or complaint investigations.

3. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on three non-consecutive surveys and/or complaint investigations.

B. Medicare Standards Out of Compliance . For purposes of this section, the applicable Medicare Standards are the Standards under each of the above-referenced Medicare Conditions of Participation, with special emphasis on standards found at 484.10 (b)(4), (b)(5),and (c); 484.12 (a) and (c); 484.14 (c)(d) and (g); 484.18 (b) and (c); 484.30 (a); 484.36 (c); and 484.52 (b). No later amendments to or editions of 42 CFR 484 are included. Copies of 42 CFR 484 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 or the material may be examined at any State Publications Depository Library.

1. Any Home Health Agency that receives repeated deficiency citations on the same standard, or standards, more man twice, or less often if the scope and severity is high.

2. Number of, as well as severity and scope of deficiency citations against standards shall be considered as factors in decisions to deny or terminate provider agreements.

C. Improper Billing Practices : Any Home Health Agency that is found by .the State or its agent(s) to have engaged in the following practices may he denied or terminated from participation in Colorado Medicaid:

1. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the client's home. Providers shall submit or produce requested documentation in accordance with rules at 8.079.62.

2. Billing for unnecessary visits, or visits that are unreasonable in amount, frequency and duration; especially nursing visits solely for the purpose of assessment and teaching.

3. Billing for home health aide visits on which no skilled tasks were performed and documented, or the skilled tasks performed were not medically necessary.

4. Billing for home health services provided at locations other than the client's, place of residence. This rule shall not apply for out-of-home Services provided with prior authorization as EPSDT extra-ordinary Home Health.

5. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any Home Health Agency that

is also certified as a personal care/homemaker provider, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:

a. One employee makes one visit, and the agency bills Medicaid for one home health aide visit, and bills all the hours as HCBS personal care or homemaker.

b. One employee makes one visit, and the agency bills for one home health aide visit, and bills some of the hours as HCBS personal care or homemaker, when the total tune spent on the visit does not equal at least 2 ½ hours plus the number of hours billed for personal care and homemaker.

c. Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 ½ hours.

d. One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 ½ hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.

e. One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 ½ hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.

f. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.

g. If any of the above practices occur, the Home Health Agency shall not be absolved from liability by failure or refusal to include personal care and/or homemaking needs on the Home Health plan of care.

1. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 5 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

2. Billing for excessive units of home health aide services for all time periods during which regulations are in effect defining the unit for home health aide as hour and/or half hour increments.

8. Billing for any services that are found to be out of compliance with any of the rules in this section, including but not limited to, those found in post-payment review rules at 8.529.

D. Prior Termination From Medicaid Participation , A Home Health Agency shall be denied or

terminated from Medicaid participation if the agency or its owner(s) have previously been involuntarily terminated from Medicaid participation as a Home Health Agency or any other type of service provider.

E. Abrupt Prior Closure . A Home Health Agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

20. Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the State, the Medical Services Board, or the State's fiscal agent.

21. When a Home Health Agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.

8.527 PRIOR AUTHORIZATION

.10 ACUTE HOME HEALTH

Acute Home Health services, as defined at Section 8.523, ELIGIBILITY, do not require prior authorization. This includes episodes of Acute Home Health for Long Term Home Health clients.

.11 LONG TERM HOME HEALTH

Long Term Home Health services, as defined at Section 8.523, ELIGIBILITY, shall be prior authorized according to the requirements below.

A. PRIOR AUTHORIZATION PROCESS

Long Term Home Health services provided to clients 18 and over shall be prior authorized by the Single Entry Point Agencies. Long Term Home Health services provided to clients under 18 shall be prior authorized by the Medicaid fiscal agent.

1. Upon admission of a client 18 and over to Long Term Home Health services, the Home Health Agency shall contact the Single Entry Point Agency to inform the case manager of the client's need for Home Health services.

2. The Home Health Agency shall submit the formal written prior authorization request to the Single Entry Point Agency for clients 18 and over and to the Medicaid fiscal agent for clients under 18, within 10 working days of the "from" date on the Home Health plan of care. Physician signature on the plan of care is not needed for prior authorization purposes. The SEP shall not send the prior authorization to the fiscal agent until the Home Health Agency submits the formal, complete, written prior authorization request (PAR).

3. The complete formal written PAR shall include:

a. A completed State-prescribed Prior Authorization Request Form;

b. A Home Health plan of care which shall include nursing and/or therapy assessments for clients under 18 and nursing assessments for clients over 18, and current clinical summaries or updates of the client. The plan of care shall be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form shall be completed. For clients under 18, all therapy services requested shall be included in the plan of care or addendum, which shall list the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.528.11.B and C, are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided.

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

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

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

4. Authorization time frames:

a. Prior authorization requests shall be submitted and may be approved for up to a one year period. For clients 18 and over, the Single Entry Point Agencies shall communicate this date to the Home Health Agencies. For clients under 18, the Medicaid fiscal agent shall communicate this date to the Home Health Agencies.

b. Home Health Agencies shall not be required to change dates on the Home Health plans of care to match the SEP program certification dates.

c. For clients 18 and over, Home Health Agencies shall send Single Entry Point Agencies new plans of care every two (2) months, and other documentation as requested by the SEP agency. For clients under 18, the information referred to in this section shall be sent to the Medicaid fiscal agent.

d. Single Entry Point Agencies, for clients 18 and over, and the Medicaid fiscal agent, for clients under 18, may initiate PAR revisions if the plans of care indicate significantly decreased services.

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

5. The prior authorization request shall be reviewed by the Single Entry Point Agency or

the Medicaid fiscal agent, as applicable, to determine compliance with Medicaid rules, and shall be approved, denied, or returned for additional information within 10 working days of receipt. The PAR shall not be backdated to a date prior to the 'from' date of the HCFA-485.

6. The Single Entry Point Agency or the Medicaid fiscal agent, as applicable, shall approve or deny according to the following guidelines for safeguarding clients:

    a. PAR Approval: If services requested are in compliance with Medicaid rules, the services shall be approved retroactively to the start date on the PAR form.

    b. PAR Denial:

        1. The Single Entry Point Agency or the Medicaid fiscal agent, as applicable, shall notify Home Health Agencies of denials based on non-compliance with Medicaid rules on the appropriate PAR form. Denials based on medical necessity, (the PAR is not consistent with the client's documented medical needs and functional capacity), shall be determined and signed by a registered nurse or physician. The Utilization Review Contractor shall notify the client of a determination of denial for level of care.

        2. SEPs, through the Medicaid fiscal agent, shall notify clients of LTHH denials, including partial denials, and appeal rights in accordance with Section 8.393.28 and Section 8.059.16, APPEALS RELATED TO REQUESTS FOR PRIOR AUTHORIZATIONS.

        3. If any services have already been provided, but are subsequently denied on the prior authorization request, the Single Entry Point Agency or the Medicaid fiscal agent, as applicable, shall notify the Home Health Agency. Services already provided shall be approved for payment, retroactive to the start date on the PAR form, or 30 working days whichever is shorter. (This 30 working days includes a 10 day period for the HHA to submit the PAR, a 10 day period for the Utilization Review Contractor to determine level of care for adult clients, and a 10 day period for the SEP to complete an assessment or the Medicaid fiscal agent, as applicable, to approve, deny, or request further information.) If denied, services shall be approved for 15 additional days after the date on which the notice of denial is mailed to the client, so that the client's right to advance notice is preserved. An informal case conference may be arranged to discuss disagreements. If the disagreement is not satisfactorily resolved, the Home Health Agency may file a provider appeal in accordance with Section 8.050, PROVIDER APPEALS.

7. Neither the presence nor the absence of a preliminary authorization or a formal written PAR approval from the authorizing agent shall exempt a Home Health Agency at any time from:

    a. Following all applicable Medicaid rules;

    b. Providing only services that are medically necessary to the needs of the

client; or

c. Ensuring the accuracy of preliminary and formal written PAR information provided to the SEP.

8. EXPEDITED AUTHORIZATION PROCESS

If requested by a Home Health Agency, for extreme emergencies or complicated cases, following the initial assessment by the Home Health Agency, and after receipt of HCFA-485 or care notes in writing, the SEP or the Medicaid fiscal agent, as applicable, may use the information provided by the Home Health Agency to take one of the following actions:

a. Provide preliminary authorization of the services, including a Case Manager (CM) signed, department approved, preliminary authorization form, in writing, until the formal written PAR procedure delineated at 8.527.11,A, 1-8 above is completed. If an expedited authorization was provided by the SEP or the Medicaid fiscal agent, as applicable, the date of service effective under the expedited authorization (never dated back prior to "from" date on HCFA-485) shall be indicated on the prior authorization form that is forwarded to the fiscal agent.

b. Provide preliminary authorization of the services, including a CM signed, department approved, preliminary authorization form, in writing, for a lesser amount of time than a) above, based on the needs of the client or the need for additional information;

c. Postpone/deny preliminary authorization until such time as the Home Health Agency provides full documentation as delineated at 8.527.11,A, 3 above. The Home Health Agency shall submit a formal written PAR in order for due process to occur as delineated at 8.527.11,A,6.

9. If the client has an acute episode, the Home Health Agency shall bill for Acute Home Health, in accordance with billing manual instructions, without obtaining prior authorization from the applicable agency. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within ten (10) working days of the beginning and within ten (10) working days of the end of the acute care episode.

10. Transition

a. SEP CLIENTS

For clients already receiving Long Term Home Health services prior to July 1,2001, the Home Health Agency shall contact the SEP Agency prior to the beginning of the next Home Health certification period, and submit prior authorization requests to the SEP for services beginning with the next Home Health certification period as delineated in 8.527.11.A.3.a-e.

Note: The Section numbered 8.527.11 B was deleted effective July 1,2002.

.12 EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES

Extra-ordinary Home Health services may be provided when identified as medically necessary through an Early Periodic Screening Diagnosis and Treatment (EPSDT) screen, and prior

authorized according to the requirements below.

A. Extra-ordinary Home Health services above and beyond the restrictions in these rules at SECTION 8.520 through 8.530.103 shall include:

1. Any combination of necessary Home Health services that exceed the maximum allowable limit per day;

2. Any Home Health services that must, for medical reasons, be provided at locations other than the child's place of residence;

3. Home Health aide services for the purpose of providing only unskilled personal care.

B. Extra-ordinary Home Health services above and beyond the restrictions in these rules at SECTION 8.520 through 8.530.10,B shall not include services that are available under other Colorado Medicaid benefits, and for which the client is eligible, including but not limited to, Private Duty Nursing, Section 8.540; HCBS personal care, Section 8.489; School Health and Related Services, Section 8290, or out-patient therapies, Section 8.330. Exceptions may be made if extra-ordinary Home Health services will be more cost-effective, provided that client safety is assured. Such exceptions shall in no way be construed as mandating the delegation of nursing tasks.

C. Prior authorization requests for EPSDT extra-ordinary Home Health shall be submitted and processed as follows:

1. The complete prior authorization request shall include a State-prescribed Prior Authorization Request Form; a plan of care which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client; written documentation of the' results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance; and any other medical information which will document the medical necessity for the extraordinary Home Health services. The plan of care shall be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form shall be completed. All therapy services requested shall be included in the plan of care, which shall list the specific procedures and modalities to be used and the amount, duration and frequency. The prior authorization request shall include detailed information on each planned Home Health visit, including the approximate times in and out, all tasks to be performed on each visit, and the place of service for each visit All Home Health services to be provided, both ordinary Home Health and extra-ordinary Home Health, shall be included in the prior authorization request Physician signature on the plan of care is not needed for prior authorization purposes.

2. The prior authorization request shall be sent to the State or its agent.

3. The prior authorization request shall be reviewed by the State or its agent to determine compliance with EPSDT guidelines, and shall be approved, denied, returned as incomplete or referred for Private Duty Nursing review, within 10 working days of receipt.

4. No services shall be approved for dates of service prior to the date of receipt of the complete prior authorization request by the State or its agent.

5. The State or its agent shall notify' clients of adverse decisions and appeal rights in accordance with Section 8.057 through 8.059.147, RECIPIENT APPEALS

PROTOCOLS/PROCESS. If services have already been provided, but will not be reimbursed by Medicaid because of late submission of me prior authorization request, only the Home Health Agency shall be notified, and the Home Health Agency may file a provider appeal according to Section 8.049, RECONSIDERATION APPEAL OF ADVERSE ADMINISTRATIVE ACTION.

.13 Prior authorization requests shall be submitted and processed as follows:

A. The complete prior authorization request must include a State-prescribed Prior Authorization Request Form; a physician-signed plan of care which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client; written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance; and any other medical information which will document the medical necessity for the extraordinary Home Health services. The plan of care must be on the HCFA-485 form or a form that is identical in format to the HCFA-485, and all sections of the form must be completed. All therapy services requested must be included in the plan of care, which must list the specific procedures and modalities to be used and the amount, duration and frequency.

B. The prior authorization request must be sent to the State or its agent.

C. The prior authorization request shall be reviewed by the State or its agent to determine compliance with EPSDT guidelines, and shall be approved, denied, returned as "unable to approve or deny due to insufficient information", or referred for physician review, within 10 working days of receipt

D. No services shall be approved for dates of service prior to the date of receipt of the complete prior authorization request by the State or its agent.

E. The State or its agent shall notify clients of adverse decisions and appeal rights in accordance with Section 8.057 through 8.059.147, RECIPIENT APPEALS PROTOCOLS/PROCESS. If services have already been provided, but will not be reimbursed by Medicaid because of late submission of the prior authorization request, only the Home Health Agency shall be notified, and the Home Health Agency may file a provider appeal according to Section 8.049, RECONSIDERATION APPEAL OF ADVERSE ADMINISTRATIVE ACTION.

8.528 REIMBURSEMENT

.10 CLAIMS

Claims shall be submitted to the fiscal agent according to Section 8.040, RULES GOVERNING SUBMISSION OF CLAMS, and Section 8.043, TIMELY FILING REQUIREMENTS.

Home Health providers shall maintain adequate financial records for all claims, including documentation of services as specified at Section 8.040.2, RULES GOVERNING SUBMISSION OF CLAIMS, and Section 8.130, PROVIDER AGREEMENTS.

.11 UNIT OF REIMBURSEMENT

A. The unit of reimbursement for the Home Health services of nursing, physical therapy, occupational therapy, and speech therapy shall be one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.

B. The Basic Unit of reimbursement for home health aide services shall be up to one hour. A unit

of time that is less than fifteen minutes shall not be reimbursable as a basic unit.

C. For home health aide visits that last longer than one hour, Extended Units may be billed in addition to the Basic Unit. Extended Units shall be increments of fifteen minutes up to one-half hour. Any unit of time that is less than fifteen minutes shall not be reimbursable as an extended unit.]

D. Reimbursement for supplies used by Home Health agency staff is included in the reimbursement for nursing, home health aide, physical therapy, occupational therapy, and speech/language pathology services, to the following extent:

1. Supplies used during provision of any Home Health services by Home Health agency staff for the practice of universal precautions shall be the financial responsibility of the Home Health agency. This excludes gloves used for bowel programs and catheter care but includes all other supplies required for the practice of universal precautions by Home Health agency staff. If a Home Health agency asks a client to provide such supplies, this will constitute a failure to accept Medicaid payment in full, in violation of Section 8.012, PROHIBITION OF CHARGES TO RECIPIENTS.

2. Supplies other than those required for practice of universal precautions which are used by the Home Health agency staff to provide Home Health care services shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

3. Supplies used for the practice of universal precautions by the client's family or other informal caregivers shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

.12 The following restrictions shall be placed on Home Health services for purposes of reimbursement:

A. Nursing visits shall not be reimbursed by Medicaid if solely for the purpose of psychiatric counseling, because that is the responsibility of the Mental Health Assessment and Services Agencies. Nursing visits for mentally ill clients shall be reimbursed under Medicaid Home Health for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.

B. The state shall not authorize nor reimburse home health aide services for the purpose of providing only unskilled personal care and/or homemaking services. Units during which unskilled personal care and/or homemaking services are provided and billed under the home health aide benefit must be contiguous with units during which services defined as skilled personal care are provided. For clients who are also eligible for HCBS personal care and homemaker services, the units spent on unskilled personal care and homemaker services and billed as aide services shall be reasonable in relation to the skilled care provided on the contiguous units. For example, if the transfer and bath are skilled, it would be reasonable for the aide to also dress the client, and to wipe up any water spills on the bathroom floor, and to prepare a meal if the aide is there at mealtime. It would not be reasonable for the aide to stay four more hours to do all the weekly cleaning and laundry, unless the client is not eligible for homemaker services under HCBS.

C. The maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed $270, effective July 1, 2002, for Acute Home Health Services

or Long Term with Acute Episode Home Health Services; and shall not exceed $211, effective My 1, 2002, for Long Term Home Health Services.

Effective September 1, 2002, the maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed S291 for Acute Home Health Services or Long Term with Acute Episode Home Health Services, and shall not exceed $227 for Long Term Home Health Services.

Criteria for the three different categories of care are found at 8.523.11, K in this section. The maximum daily reimbursement includes reimbursement for nursing visits, home health aide units, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof.

D. Medicaid will not reimburse for two nurses during one visit, two home health aides at the same time, two physical therapists during one visit, two occupational therapists during one visit, or two speech therapists during one visit. An exception to this rule is for two home health aides, when two are required for transfers, and there are no other, persons available to assist, and when there is a justifiable reason why adaptive equipment cannot be used instead. Another exception is for two nurses when two are required to perform a procedure. For these exceptions, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

E. If a client is seen simultaneously by two persons to provide a single service, for which one person supervises or instructs the other, the Home Health agency shall only bill and be reimbursed for one employee's visit or units. For example, if two nurses visit the client, and the first nurse provides care and also orients and trains the second nurse in the client's care, only the first nurse's time counts as a reimbursable visit.

F. Any visit made solely for the purpose of supervising the home health aide shall not be reimbursed.

G. Any visit made by a nurse or therapist to simultaneously serve two or more clients residing in the same household shall be reimbursed as one visit only, unless services to each client are separate and distinct. If two or more clients residing in the same household receive Medicaid home health aide services, the personal care for each client shall be documented and billed separately for each client. Any homemaker services provided during units contiguous to skilled personal care units shall be billed to any one of the clients in the household, but the homemaker services shall not be duplicated and/or billed for more than one client. For example, if more than one client in the household needs meal preparation, it is expected that one aide prepare the meal for all of them. If the clients in the same household use different agencies, the agencies shall coordinate with each other to prevent duplication of homemaking.

H. No more than one Home Health agency shall be reimbursed for providing Home Health services during a specific plan period to the same client, unless the second agency is providing a Home Health service that is not available from the first agency. The first agency must take responsibility for the coordination of all Home Health services. Home and Community Based Services, including personal care, are not Home Health services.

I. Physical, occupational, or speech therapy visits shall be reimbursed only when:

1. Improvement of functioning is expected or continuing;

2. The therapy assists in overcoming developmental problems;

3. Therapy visits are necessary to prevent deterioration;

4. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration; and to teach home health aides or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; and/or

5. Therapy visits are indicated to assess the safety or optimal functioning of the client in the home, or to train in the use of equipment used in implementation of the therapy plan of care.

J. Nursing visits provided solely for the purpose of assessing and/or teaching shall be reimbursed by Medicaid only under the following guidelines:

1. For an initial assessment visit ordered by a physician when there is a reasonable expectation that ongoing nursing or home health aide care may be needed. Initial nursing assessment visits shall not be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.

2. If a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the client or the client's unpaid family/caregiver how to perform the task, that visit shall not be considered as being solely for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the client or unpaid family/caregiver performing the task to verify that the task is being performed correctly shall be considered a visit that is solely for the purpose of assessing and teaching.

3. Nursing visits solely for the purpose of assessing the client and/or teaching the client or the client's unpaid family/caregiver shall not be reimbursed unless the care is Acute Home Health or Long Term Home Health With Acute Episode, as defined in Section 8.523, ELIGIBILITY, or the care is for extreme instability of a chronic condition under Long Term Home Health, as defined in Section 3.523, ELIGIBILITY.

4. Nursing visits provided solely for the purpose of assessment and/or teaching shall not exceed the frequency that is justified by the client's documented medical condition and symptoms, up to the maximum reimbursement limits. Assessment visits shall continue only as long as there is documented clinical need for assessment, management, and reporting to physician of specific conditions and/or symptoms which are not stable and/or not resolved. Teaching visits shall be as frequent as necessary, up to the maximum reimbursement limits, to teach the client or the client's unpaid family/caregiver, and shall continue only as long as needed for the client or the client's unpaid family/caregiver to demonstrate understanding or to perform care, or until it is determined that the client or unpaid family/caregiver is unable to learn or to perform the skill being taught. The visit on which the nurse determines that there is no longer a need for assessment and/or teaching shall be reimbursed if it is the last visit provided solely for assessment and/or teaching.

5. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if the client is capable of self-assessment and of contacting the physician as needed; and if the client's medical records do not justify a need for client teaching beyond that already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment

6. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if there is an available and willing unpaid family/caregiver who is capable of assessing the client's condition and needs and contacting the physician as needed; and if the client's medical records do not justify a need for teaching of the client's unpaid family/caregiver beyond the teaching already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment.

K. Nursing visits provided solely for the purpose of assessment and/or teaching and foot care shall not be reimbursed unless the visit meets the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, and/or the guidelines to be reimbursed as a foot care visit.

Nursing visits provided solely for the purpose of providing foot care shall be reimbursed by Medicaid only if the client has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the client and/or unpaid family/caregiver is not able or willing to provide the foot care. This will include documented and supported diagnoses that involve severe peripheral involvement, anti-coagulation therapy, or other conditions such as, but not limited to, spasticity and compromised immune system which could lead to a high risk of medical complications from injuries to the feet.

Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit The clinical record must indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for footcare to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:

1. absent (not palpable) posterior tibial pulse;

2. absent (not palpable) dorsalis pedis pulse;

3. three of the advanced trophic changes such as:

    a. hair growth (decrease or absence),

    b. nail changes (thickening),

    c. pigmentary changes (discoloration),

    d. skin texture (thin, shiny),

    e. skin color (rubor or redness);

4. claudication (limping, lameness);

4. temperature changes (cold feet);

5. edema;

6. parasthesia;

7. burning.

L. Nursing visits provided solely for the purpose of assessment and/or teaching and pre-pouring

of medications shall not be reimbursed unless the visit meets either the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, or the guidelines for reimbursement as a visit solely for the purpose of pre-pouring medications. Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers shall be reimbursed by Medicaid under the following guidelines:

1. The client is not living in a licensed personal care boarding home, including Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at 25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015. No later amendments to or editions of 25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015 are included. Copies of 25-1-107 (ee) (L5), C.R.S., as amended by House Bill 98-1015 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714 or the material may be examined at any State Publications Depository Library; and

2. The client is not physically or mentally capable of pre-pouring his/her own medications or has a medical history of non- compliance with taking medications if they are not pre-poured; and

3. The client has no unpaid family/caregiver who is willing or able to pre-pour the medications for the client; and

4. There is documentation in the client's chart that the client's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular client.

M. Nursing visits solely for the purpose of performing venipuncture, or for venipuncture and assessment and/or teaching, shall be reimbursed only if all the regulations in Section 8.520 through Section 8.530.10, B, HOME HEALTH SERVICES, are met.

.13 RATES OF REIMBURSEMENT

A. Payment for Home Health services, other than nursing visits, shall be the lower of the billed charges or the maximum unit rate of reimbursement.

For nursing visits the payment shall be the lower of the billed charges, the maximum unit rate of reimbursement or prior authorized charges.

Prior authorized charges for stable clients requiring daily visits shall not exceed $50.00 for the first brief nursing visit of the day and $35.00 for the second or subsequent brief nursing visit of the day.

B. Maximum interim payment unit rates are:

Effective July 1, 2002:

1. Nursing visits: $67.85

2. Acute Home Health Aide Basic unit: $22.37

3. Long Term Home Health Aide Basic unit: $30.08

4. Home Health Aide Extended unit: $8.99

5. Physical Therapy visits: $58.36

6. Occupational Therapy visits: $61.98

7. Speech Therapy visits: $63.60

Effective September 1, 2002:

1. Nursing visits: $71.42

2. Any Home Health Aide Basic unit $31.66

3. Home Health Aide Extended unit: $9.46

4. Physical Therapy visits: $61.43

5. Occupational Therapy visits: $65.24

6. Speech Therapy visits: $66.95

Effective February 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 99-00. The interim rates shall not be reduced, if total Medicaid home health expenditures in State FY 99-00 do not exceed $73,571,787. If total expenditures for the Home Health budget do exceed $73,571,787, the Department shall determine which Home Health Agencies received average per unduplicated client payments for State FY 99-00 Home Health services which were more than 16.5% over State FY 98-99 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each agency's unit rates, retro-active to February 1, 2000, by a percentage that will bring each agency's average payment per unduplicated client for State FY 99-00 to no more than a 16.5% increase over its State FY 98-99 average per unduplicated client payment. Agencies that became newly certified as Medicare/Medicaid providers in State FY 99-00 and have no Medicaid Home Health payment history for State FY 98-99 shall be exempt.

D. Effective September 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 00-01 with the following exemptions:

1. Exempt Agencies

    a) Agencies that became newly certified as Medicare/Medicaid providers in State FY 00-01 and have no Medicaid Home Health payment history for State FY 99-00 shall be exempt.

    b) Agencies that had total Medicaid Home Health payments of less than $125,000 in FY 99-00 shall be exempt.

2. Exempt Clients

    a) Clients who are newly enrolled in Medicaid shall be exempt if they receive Medicaid Home Health services within thirty days of their very first

Medicaid enrollment. Clients with prior spans of Medicaid eligibility shall not be considered newly enrolled even if there was a period of non-enrollment between eligibility spans.

b) Clients who are deinstitutionalized from nursing facilities shall be exempt if the nursing facility care was billed to Medicaid and was not billed as respite care; if they begin receiving Home Health services no later than thirty days after discharge, from the nursing facility; and if they do not return to nursing facility placement after an interim period of Home Health care.

E. The FT 00-01 interim rates shall not be reduced if total Medicaid community long term care expenditures in State FY 00-01 do not exceed $198,862,688. If total expenditures for the community long term care budget do exceed $198,862,688, the Department shall determine which non-exempt Home Health Agencies received average per non-exempt unduplicated client payments for State FY 00-01 Home Health services which were more than 16.5% over State FY 99-00 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each non-exempt agency's unit rates, retroactive to September 1, 2000, by a percentage that will bring each agency's average payment per non-exempt unduplicated client for State FY 00-01 to no more than 16.5% increase over its State FY 99-00 average per unduplicated client payment.

F. Services shall be billed according to category of service upon publication of instructions in the provider-billing manual.

1. For Acute Home Health Services, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health.

2. For Long Term Home Health Services provided to a minor, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy as Long Term Home Health. For Long Term Home Health Services provided to an adult, Home Health Agencies shall bill nursing, and home health aide services as Long Term Home Health. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201. A.

3. For Long Term with Acute Episode Home Health Services, Home Health Agencies shall bill all nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health, until the client's care becomes Long Term Home Health again.

4. For <u>all</u> nursing visits provided solely for the purpose of assessment and teaching, not including initial assessment visits at the start of care, Home Health Agencies shall bill a revenue code assigned for nursing assessment and teaching visits.

G. Maximum unit rates may be adjusted by the State as funding becomes available.

.14 SPECIAL REIMBURSEMENT CONDITIONS

A. Reimbursement for third party resource and Medicare crossover claims shall not exceed Medicaid costs.

B. When Home Health agencies provide Home Health services, in accordance with these regulations, to clients who receive Home and Community Based Services for the

Developmentally Disabled (HCBS-DD), the Home Health agency shall be reimbursed:

1. Under normal procedures for Home Health reimbursement, if the client resides in an Intensive Adult Residential Service group home, a personal care host home, or personal care alternatives home; or

2. By the group home provider, if the client resides in a Moderate Supervision Group Home, or Specialized Group Home, because the group home has already received Medicaid funding for the home health services and is responsible for payment to the Home Health agency.

C. Acute Home Health services provided to Medicaid HMO clients, including Medicaid HMO clients who are also HCBS recipients, shall not be reimbursed under the Medicaid Home Health program, but shall be reimbursed under Medicaid HMO rules. If a client's Home Health service need exceeds 60 days, the Home Health Agency shall submit a Prior Authorization for Long Term: Home Health to the Single Entry Point agency, if the client is 18 years old: or more; or to the Medicaid fiscal agent if the client is less than 18 years old.

.15 COST REPORTING

A. All Home Health agencies shall report and submit to the Department cost report information on a Department prescribed form for home health aides, nurses, occupational, physical and speech therapists.

B. By dates set forth by the Department, home health providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or State fiscal year.

C. Providers that do not comply with Section 8.528.15 shall have their Medicaid provider agreement terminated.

8.529 POST-PAYMENT REVIEW

.10 The Medicaid Quality Assurance Unit shall periodically conduct post-payment reviews of selected Home Health services.

.11 Home Health agencies shall submit or produce requested documentation of services to the Medicaid Quality Assurance Unit in accordance with rules at 8.079.62. Such documentation shall include, at a minimum:

A. Physician-signed plans of care, which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client. The plan of care must be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form must be completed. All therapy services provided must be included in the plan of care, which must list the specific procedures and modalities to be used and the amount, duration and frequency.

B. Records documenting the nature and extent of the care actually provided such as, but not limited to, nursing notes.

.12 The Medicaid Quality Assurance Unit shall review all information available from any source, shall contact clients, and may conduct on-site visits to Home Health agencies and/or clients.

.13 The Medicaid Quality Assurance Unit shall initiate appropriate administrative, civil, or criminal investigations and/or sanctions for all services which:

A. Are found to be out of compliance with all applicable regulations;

B. Are not consistent with the client's documented medical needs and functional capacity,

C. Are not reasonable in amount, frequency, and duration;

D. Are duplicative of any other services that the client received or that the client received funds to purchase;

E. Total more than twenty-four hours per day of paid care, regardless of funding source (An example of care totaling more than 24 hours per day would be 5 home health visits plus 12 hours of personal care);

F. Consist of visits or contiguous units which are shorter or longer than the length of time required to perform all the tasks prescribed on the care plan.

.14 Clients and families of clients shall not be billed by home health agencies for any services for which Medicaid reimbursement is recovered as a result of post-payment review.

.15 Providers may appeal post-pay sanctions in accordance with Section 8.050, PROVIDER APPEALS AND HEARINGS.

8.530 DENIAL, TERMINATION, OR REDUCTION IN SERVICES

.10 When services are denied, terminated, or reduced by action of the Home Health agency, the Home Health agency shall notify the client.

A. Termination of Services to Clients Still Medically Eligible for Coverage of Medicaid Home. Health Services

When a Home Health agency decides to terminate services to a client who needs and wants continued Home Health services, and who remains eligible for coverage of services under the Medicaid Home Health rules , the agency shall give the client, and/or the client's designated representative, written advance, notice of at least fifteen business days, and the attending physician shall also be notified. Notice shall be provided in person or by certified mail, and shall be considered given when it is documented that the recipient has received the notice. The notice shall provide the reason for the change in services. The agency shall make a good faith effort to assist the client in securing the services of another agency. If there is indication that ongoing services from another source can not be arranged by the end of the advance notice period, the terminating agency shall ensure client safety by making referrals to appropriate case management agencies and/or County Departments of Social Services; and the attending physician shall be informed about the situation. Exceptions will be made to the requirement for 15 days advance notice when the provider has documented that there is danger to the client, Home Health agency, staff, or when the client has begun to receive Home Health services through a Medicaid HMO. Clients who believe that a Home Health agency has not acted properly, in terminating services may call me Home Health Hotline, at 1-800-842-8826 to request an investigation.

NOTE: Section 8.530.10.B.was deleted effective September 1,2002.

8.540 PRIVATE DUTY NURSING SERVICES

8.540.1 DEFINITIONS

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]*

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]*

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]*

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]*

Re-Hospitalization means any hospital admission that occurs after the initial hospitalization for the same condition. *[Eff 08/01/2006]*

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]*

Technology Dependent means a client who: *[Eff 08/01/2006]*

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]*

8.550 HOSPICE BENEFIT

8.550.1 DEFINITIONS

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:

(1) An initial 90-day period.

(2) A subsequent 90-day period.

(3) An unlimited number of subsequent 60-day periods.

The periods of care are available in the order listed and may be Elected separately at different times.

Certification means that the client's attending physician and/or the Hospice medical director have affirmed that the client is Terminally Ill.

Election/Elect means the client's written expression to choose Hospice care for Palliative and Supportive Medical Services. 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.

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.

Hospice Services means counseling, home health aide, homemaker, nursing, physician, social services, physical therapy, occupational therapy, speech therapy, and trained volunteers.

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 six 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.

8.551 CONSUMER DIRECTED ATTENDANT SUPPORT

8.551.1 DEFINITIONS

Authorized Representative means an individual designated by the consumer of attendant support or the legal guardian of the consumer of attendant support, if appropriate, who has the judgment and ability to assist the consumer of attendant support in acquiring and utilizing services under the Consumer Directed Attendant Support program. The Authorized Representative shall not be the consumer's service provider.

Attendant means the individual who provides attendant support services as set forth at §8.551.2.

Attendant Support Management Training means the required training, including a final, comprehensive test, provided by the Department or its designee to program applicants who meet program eligibility and who have been selected for the program and/or to Authorized Representatives.

Fund for Additional Services means the account that reflects a portion of accumulated savings by Program Participants resulting from their use of less than their full Individual Allocation, and which is available to Program Participants by application.

Individual Allocation means the funds made available by the Department to Program Participants and administered by an Intermediary Service Organization. These funds shall be available each month that a Program Participant meets program eligibility and shall be calculated based on the Program Participant's history of attendant support utilization or on the personal care, homemaker, home health aide, and nursing services defined in the client's care plan.

Intermediary Service Organization means the entity or entities under contract with the Department to provide financial and personnel administration for a Program Participant.

Program Participant means an individual who meets all program eligibility criteria, who has completed Attendant Support Management Training, who has been notified by the Department of his or her enrollment in the program and who desires to continue participating in the program.

8.551.2 COVERED SERVICES

Covered services in the Consumer Directed Attendant Support Program (CDAS) shall be attendant support, which includes skilled nursing services and home health aide services, Long Term Home Health and Long Term with Acute Episode Home Health as defined under the Home Health Program at 10 C.C.R. 2505-10, §8.520 et seq. and Personal Care and Homemaker Services, as defined under the Long-Term Care Program at 10 C.C.R. 2505-10, §8.489 and §8.490.

8.551.3 ELIGIBILITY

8.551.3.A. REFERRAL/SCREENING/INTAKE

1. An individual wishing to apply for CDAS shall submit an application and supporting documentation to the Department.

2. The individual shall submit a statement from the individual's primary care physician or treating physician that indicates that the individual has sound judgment and the ability to direct his or her care or has an Authorized Representative and who is in stable condition, both physically and emotionally.

3. All applicants shall receive written notification as to whether they have been determined eligible.

4. Applicants denied admission to the program shall receive written notification within 20 calendar days of that denial. The written notification shall explain the reasons for denial and provide information on rights to a fair hearing and appeal procedures, described at 10 C.C.R. §8.057 *et seq.*

8.551.3.B. ELIGIBILITY CRITERIA

To be eligible for CDAS, an individual shall:

1. Be willing to participate in the pilot program.

2. Be eligible for Medicaid. Individuals who receive Home and Community-Based Services (HCBS) personal care as the only HCBS service, and who are eligible for Medicaid only because of eligibility for an HCBS waiver, shall be considered to be enrolled in the HCBS waiver when they substitute CDAS services for HCBS personal care.

3. Demonstrate a current need for attendant support.

4. Document a pattern of stable health, which is a condition of health that necessitates a predictable pattern of attendant support, allowing for variation that is consistent with a medically predictable progression or variation of disability or illness. The documentation may include the individual's history of utilization of Medicaid-funded attendant support.

5. Demonstrate the ability to handle the financial aspects of self-directed attendant support, either through prior experience or through completion of Attendant Support Management Training or have an Authorized Representative who is able to handle the financial aspects of self directed attendant support. Ability to handle the financial aspects of self-directed attendant support means:

    a. The ability to determine how the Individual Allocation should be spent to ensure that the individual receives necessary attendant support, both in quantity and quality, and to ensure that Attendants receive appropriate compensation; and

    b. The ability to verify the accuracy of financial and personnel records as provided by the Intermediary Service Organization.

6. Demonstrate the ability to manage the health aspects of his or her life, either through prior experience or through completion of Attendant Support Management Training or have an Authorized Representative who is able to manage the health aspects of his or her life. Managing the health aspects of one's life includes the ability to understand principles and monitor conditions of basic health and the knowledge of how, when and where to seek medical help of an appropriate nature.

7. Demonstrate the ability to supervise Attendants, either through prior experience or through completion of Attendant Support Management Training or have an Authorized Representative who is able to supervise Attendants. Ability to supervise Attendants means the knowledge and ability:

    a. To recruit and hire Attendants;

    b. To communicate expectations;

    c. To provide training, guidance and review for Attendants in the accomplishment of attendant tasks;

    d. To manage necessary paperwork; and

    e. To dismiss Attendants when necessary.

8.551.3.C. CONTINUING ELIGIBILITY REVIEW

A Program Participant whose continuing eligibility for CDAS has been questioned by a Single Entry Point (SEP) case manager or by the Department, shall receive a continuing eligibility review by the Department, with input from the Program Participant. The review shall assess whether the

Program Participant may take any actions to establish continuing program eligibility. The Program Participant shall be provided with the results of the review and the recommended actions.

8.551.4 PARTICIPANT SELECTION

8.551.4.A. The number of Program Participants is limited by the enrollment ceiling established in the federal waiver. The Department shall select eligible individuals according to the following process.

8.551.4.B. APPLICANT POOLS

The Department shall assign all eligible applicants to either of two applicant pools:

1. The “Metro Pool” which consists of applicants from counties the Census Bureau has designated as metropolitan (a city of at least 50,000 in population); and

2. The “Rural Pool” which consists of applicants from all other counties.

8.551.4.C. RANDOM DRAWING

The Department shall fill open program slots through a random drawing, held twice a year, of qualified applicants from the two applicant pools. The Department shall determine the number of applicants selected from each pool so as to maintain an appropriate rural/metro ratio as described below. Applicants who are selected shall participate in Attendant Support Management Training.

8.551.4.D. RURAL/METRO RATIO

Participation in CDAS shall reflect a rural/metro ratio, as determined each year by the CDAS advisory committee. The rural/metro ratio shall be not less than 5%/95% and not greater than 20%/80%.

8.551.4.E. WAITING LIST

If the number of qualified applicants exceeds the number of open slots for a given applicant pool at the time of the selection process, the Department shall use the random drawing described above and shall place applicants not selected on a waiting list for the appropriate applicant pool. The Department shall assign a date-received code to applicants placed on waiting lists. During the next selection process, the Department shall fill open slots in a given pool first from that pool’s waiting list and then by selection of new applicants. Selection from waiting lists shall be based on chronological order of the date-received codes. The Department shall use a random selection process for all applicants having the same code. The Department shall continue the process until all slots are filled or all applicants have been selected.

8.551.5 SERVICES REQUIREMENTS

8.551.5.A. CONDITIONS FOR SERVICES

An individual may receive CDAS services only after:

1. The individual meets all program eligibility criteria;

2. The individual is selected for the program;

3. The individual and/or Authorized Representative completes the Attendant Support Management Training and develops an attendant support management plan, as

described at §8.551.5(C);

4. The Department approves the attendant support management plan;

5. The Department and the individual and/or Authorized Representative determine an appropriate start date for services;

6. The Department notifies the appropriate Case Manager and Intermediary Service Organization of the effective date that the individual will be participating in CDAS;

7. The individual and/or Authorized Representative completes and signs a contract for services with the Intermediary Service Organization;

8. The individual and/or Authorized Representative signs a Program Participant responsibilities form;

9. The individual and/or Authorized Representative has completed and submitted provider notification forms informing his or her existing Medicaid-funded attendant support provider(s) of the date on which attendant support shall cease; and

10. The individual's services start date has occurred.

8.551.5.B. TRAINING REQUIREMENT

To receive CDAS services, eligible applicants and/or Authorized Representatives must complete the Attendant Support Management Training and pass the comprehensive test offered by the Department.

8.551.5.C. ATTENDANT SUPPORT MANAGEMENT PLAN

To receive services, each eligible applicant and/or Authorized Representative shall develop an attendant support management plan. The plan shall describe the individual's:

1. Current status;

2. Needs and requirements for attendant support;

3. Plans for securing attendant support;

4. Assurances and plans regarding direction of health maintenance activities, as described below, if applicable;

5. Plans for handling emergencies;

6. Plans for using the Individual Allocation; and

7. Plans for using the Fund for Additional Services.

8.551.5.D. DIRECTION OF HEALTH MAINTENANCE ACTIVITIES

1. Health maintenance activities are those routine and repetitive activities of daily living which are necessary for health and normal bodily functioning and which would be carried out by an individual with a disability if he or she were physically able, or by family members or friends if they were available. These activities include, but are not limited to, catheter care, administration of medication and ventilator monitoring.

2. A Program Participant who needs attendant support for health maintenance activities, shall direct or have an Authorized Representative direct Attendants in such activities under the following conditions:

    a. The Program Participant and/or Authorized Representative indicates on the attendant support management plan that he or she has received adequate instruction from health professionals, and is therefore qualified and able to train his or her Attendants in specified health maintenance activities.

    b. The Program Participant and/or Authorized Representative lists the specific health maintenance activities on his or her attendant support management plan for which he or she will be providing training.

    c. The Program Participant and/or Authorized Representative verifies on the attendant support management plan that Attendants who will perform health maintenance activities have had or will receive necessary training, either from the Program Participant and/or Authorized Representative or from appropriate health professionals.

8.551.5.E. PLANS FOR USE OF THE FUND FOR ADDITIONAL SERVICES

As part of the attendant support management plan approved by the Department, a Program Participant and/or Authorized Representative shall identify goals for use of the Fund for Additional Services. Program Participants and/or Authorized Representatives may apply for grants from the Fund for Additional Services to cover costs for other services and equipment that promote the person's independence or that ameliorate conditions related to the Program Participant's disability, as long as the costs for such services and equipment are not covered through other available Medicaid programs.

8.551.5.F. CONTINUATION OF EXISTING IN-HOME SERVICES

Individuals applying for CDAS shall continue with their existing Medicaid-funded attendant support arrangements until the conditions for services have been met and the start date for CDAS services occurs.

8.551.5.G. START DATE FOR SERVICES

Once an eligible applicant and/or Authorized Representative completes the Attendant Support Management Training and has received notification of that completion from the Department, the individual, in conjunction with the Department, shall establish a services start date. The eligible applicant shall have a 30-day window of time in which to finalize attendant support arrangements and to contact the Department to set the start date.

8.551.5.H. SERVICE SUBSTITUTION

1. Once an individual is enrolled in CDAS, the case manager shall disenroll him or her from any other Medicaid-funded attendant support.

2. The case manager shall notify the state fiscal agent to cease payments for all existing Medicaid-funded attendant support for the eligible applicant as of that person's services start date.

3. Case managers shall not authorize payments for CDAS attendant support and non-CDAS attendant support for the same individual.

4. To minimize the instance of accidental duplicate services, an eligible applicant shall notify his or her existing attendant support provider(s) on a provider notification form that attendant support from that provider shall cease and the date of cessation. The eligible applicant shall provide the Department with a copy of each form.

8.551.6 CALCULATION OF INDIVIDUAL ALLOCATIONS

8.551.6.A. INITIAL CALCULATION

The Department shall calculate the initial Individual Allocation for each eligible applicant as follows:

1. Identify the service categories in which payments have been made for the eligible applicant for those service categories that constitute Medicaid-funded attendant support.

2. Add the payments made on behalf of the eligible applicant for Medicaid-funded attendant support.

3. Determine the number of months of service for each eligible applicant.

4. Divide the total payments by total service months, yielding a preliminary Individual Allocation and an average monthly payment for the eligible applicant.

5. Adjust the allocation to the fiscal year of the Program Participant's services start date, incorporating the effect of non-CDAS attendant support rate changes for those service categories that constitute attendant support and considering the cost neutrality guidelines set forth in the terms and conditions from the Centers for Medicare and Medicaid Services.

6. Calculate the number of personal care, homemaker, home health aide and nursing hours needed on a monthly basis as defined in the care plan and Prior Authorization Request completed by the case manager and multiply by the Department's established rates for these services to derive a monthly allocation for applicants who have insufficient utilization history.

8.551.6.B. ADJUSTMENTS TO INDIVIDUAL ALLOCATIONS

1. A Program Participant who believes that he or she needs more attendant support than the existing Individual Allocation will cover, may request the SEP case manager to perform a reassessment, as described at §8.551.10(D). If the reassessment indicates that more attendant support is justified, the Program Participant and case manager shall recommend adjustments to the attendant support management plan with a concomitant increase in the Individual Allocation.

2. In recommending an increase in the Individual Allocation, case managers shall consider:

    a. Any change in the Program Participant's condition that would necessitate more attendant support;

    b. Discrepancies between the Program Participant's utilization history and current needs for attendant support;

    c. The appropriateness of attendant wages paid by the Program Participant for services received;

d. The quality and quantity of services provided by Attendants for the wages they receive; and

e. Revisions in the Program Participant's budgeting of the current Individual Allocation to more effectively pay for needed services.

8.551.7 PAYMENTS

8.551.7.A ATTENDANT REIMBURSEMENT

Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the Program Participant and/or Authorized Representative hiring the Attendant. The Intermediary Service Organization shall make all payments from the Program Participant's Individual Allocation under the direction of the Program Participant and/or Authorized Representative.

8.551.7.B EMPLOYER OF RECORD

The Intermediary Service Organization shall be the employer of record for all CDAS Attendants and shall be responsible for worker's compensation insurance, unemployment compensation insurance, withholding of all federal and state taxes, compliance with federal and state laws regarding overtime pay and minimum wage requirements, and compliance with any other relevant federal, state or local laws.

8.551.7.C UNSPENT PORTION OF AN ALLOCATION

Any unspent portion of a Program Participant's monthly Individual Allocation shall be divided equally between the Department and the Fund for Additional Services. Requests for a grant from the Fund for Additional Services shall be consistent with the Program Participant's current attendant support management plan. The cost of the services and equipment being requested shall not exceed the total amount contributed to the Fund for Additional Services by the Program Participant up to that point. In no circumstance shall the Department make cash grants to Program Participants.

8.551.8 PROGRAM PARTICIPANT AND AUTHORIZED REPRESENTATIVE ROLE AND RESPONSIBILITIES

8.551.8.A HEALTH AND ATTENDANT MANAGEMENT

To receive CDAS services, an individual and/or Authorized Representative shall sign a Program Participant responsibilities form acknowledging full responsibility for:

1. The individual's own health management; and

2. The individual's own attendant support management, which includes arranging for replacement of an absent Attendant, whether or not such an absence was anticipated.

8.551.8.B PROGRAM PARTICIPANT'S/AUTHORIZED REPRESENTATIVE'S RESPONSIBILITIES AS SUPERVISOR

As the supervisor of Attendants, a Program Participant and/or Authorized Representative shall:

1. Determine wages and benefits for each Attendant;

2. Establish hiring agreements with each Attendant, outlining wages, benefits, services to be provided, schedules and working conditions;

3. Follow all relevant laws and regulations regarding the employment of Attendants;

4. Explain the role of the Intermediary Service Organization to the Attendant;

5 Communicate with the Intermediary Service Organization regarding the hiring of Attendants, including wage and benefit information for each Attendant;

6. Review all Attendant time sheets for accuracy and completeness;

7. Ensure that time sheets are signed by the Program Participant and the Attendant in order for the Intermediary Service Organization to issue a paycheck to the Attendant; and

8. Authorize the Intermediary Service Organization to make any changes in Attendant wages or benefits.

8.551.8.C QUALITY ASSURANCE ACTIVITIES

Participants and/or Authorized Representatives in CDAS shall take part in assuring the quality of program services. To assess quality of care on an ongoing basis, Program Participants shall:

1. Devise and utilize an attendant support management plan, as described at §8.551.5(C). Program Participants and/or Authorized Representatives shall review their plans at least annually and modify or develop new plans as needed.

2. Submit timesheets for all Attendants to the Intermediary Service Organization.

3. Complete a self-assessment form every six months.

8.551.8.D. FINANCIAL RECONCILIATION

Program Participants, or their Authorized Representatives shall review the monthly reports from the Intermediary Service Organization for the purpose of financial reconciliation. Program Participants shall bring discrepancies and inaccuracies to the attention of the Intermediary Service Organization.

8.551.9 CDAS-SPECIFIC PARTICIPANT RIGHTS

8.551.9.A DISAPPROVAL OF MANAGEMENT PLAN REVIEW

A Program Participant and/or Authorized Representative whose attendant support management plan is disapproved by the Department has the right to review that disapproval. The Program Participant shall submit a written request to the Department stating the reasons for requesting the review and justifying the proposed management plan. The Program Participant's most recently approved management plan shall remain in effect while the review is in process.

8.551.9.B. ATTENDANT SUPPORT MANAGEMENT

A Program Participant and/or Authorized Representative in CDAS has the right:

1. To hire persons of his or her choice to provide attendant support;

2. To determine what credentials, if any, individuals must have to be employed as Attendants;

3. To train Attendants to meet his or her own particular needs;

4. To dismiss Attendants who are not meeting his or her needs;

5. To request a reassessment, as described at §8.551.10(D), if he or she believes that his or her level of service needs to be adjusted; and

6. To revise his or her attendant support management plan at any time, as long as the Department approves the revised plan.

8.551.9.C ASSISTANCE WITH FINANCIAL MANAGEMENT

A Program Participant who, because of a cognitive disability, lacks the ability to handle the financial aspects of self-directed attendant support, has the right to designate an Authorized Representative family member, friend or other support person to be responsible for financial management. A designated support person An Authorized Representative shall not direct the attendant support, nor shall he or she not receive reimbursement for financial management assistance.

8.551.9.D WITHDRAWAL FROM PROGRAM

Program Participants and/or Authorized Representatives have the right to withdraw from CDAS at any time. A Program Participant who wishes to withdraw shall contact the SEP case manager or the Department to be disenrolled from CDAS.

8.551.9.E PREVIOUS PROGRAM

A Program Participant who leaves the CDAS program, whether by choice, because the program ends, or because the Program Participant is no longer eligible for CDAS, has the right to return to his or her previous Medicaid-funded attendant support program. The Program Participant must continue to need attendant support, continue to qualify for the previous program and continue to be otherwise eligible for Medicaid.

8.551.10 CASE MANAGEMENT FUNCTIONS

SEP agencies shall provide CDAS case management and shall comply with single entry point rules governing case management functions as set forth at 10 C.C.R. 2505-10, §8.390 et seq., except that they shall comply with the following requirements when providing case management under CDAS.

8.551.10.A REFERRAL/SCREENING/INTAKE

Case managers shall provide their clients with information on CDAS and refer interested individuals to the Department for screening and intake.

8.551.10.B PLANNING

1. Case managers shall be available to assist Program Participants in planning attendant support; however, the Program Participants and/or Authorized Representatives are ultimately responsible for devising and implementing their own attendant support management plans.

2. Case managers shall not represent Program Participants in negotiations regarding attendant wages or intermediary services.

8.551.10.C. COORDINATION, MONITORING, AND EVALUATION OF SERVICES

As part of the process of coordination, monitoring and evaluation of services, case managers

shall:

1. Contact Program Participants and/or Authorized Representatives twice a month during the first three months of participation in the program to assess their attendant management, their satisfaction with care providers and the quality of services received.

2. Contact Program Participants and/or Authorized Representatives quarterly, after the first three months, to assess their implementation of service plans, attendant support management issues, quality of care, attendant support expenditures and general satisfaction.

3. Contact the Intermediary Service Organization at least at the time of reassessment, and more often as needed, to determine the status of the Program Participant's activities.

4. Assist Program Participants in securing related services as needed.

5. Refer cases to the Department to determine whether a Program Participant continues to meet program eligibility.

8.551.10.D. REASSESSMENT

Case managers shall conduct a reassessment with each Program Participant and/or Authorized Representative every six months. A reassessment under CDAS is a comprehensive face-to-face interview conducted with the Program Participant and/or Authorized Representative and appropriate collateral contacts to determine the Program Participant's level of functioning and service needs. Such a reassessment includes an evaluation by the case manager, collection of supporting information from the Program Participant's physician and the Program Participant's self-assessment of his or her needs. Case managers shall conduct additional reassessments if requested by the Program Participant or the Department. In addition to the issues monitored during the quarterly contacts, case managers shall use the six-month reassessments to review any need for adjusting Individual Allocations, as described at §8.551.6(B).

8.551.11 TERMINATION FROM CDAS

The Department shall notify the Program Participant in writing at least 15 20 calendar days prior to termination, that he or she is no longer eligible for CDAS, and that the Program Participant should contact his or her case manager for assistance in obtaining other home care services. The notice shall provide the Program Participant with the reasons for termination and with information about the Program Participant's rights to fair hearing and appeal procedures, in accordance with 10 C.C.R. 2505-10, §8.057. Exceptions will be made to the 20 day advance notice requirement when the Department has documented that there is danger to the Program Participant or to the Attendants. The Department shall notify the Program Participant's case manager and the Intermediary Service Organization of the date on which the Program Participant is being terminated from CDAS.

8.552 IN HOME SUPPORT SERVICES

8.552.1 DEFINITIONS

Case Manager means an individual who determines functional eligibility and provides case management services to individuals eligible under the HCBS-Children's Waiver program at 10 C.C.R. 2505-10, Section 8.506.7 or the HCBS-EBD Waiver program 10 C.C.R. 2505-10, Section 8.485.

Health Maintenance Activities means those routine and repetitive health related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These Activities include, but are not limited to, catheter irrigation, administration of medication,

enemas and suppositories and wound care.

In Home Support Services (IHSS) means services that are provided by an attendant and include Health Maintenance Activities and support for activities of daily living which include homemaker and personal care services.

IHSS Plan means a written plan of IHSS between the client and/or the client's guardian or authorized representative and the IHSS agency. The Plan shall include a statement of allowable attendant and personal care service hours, a detailed listing of amount, scope and duration services to be provided, a dispute resolution process, who will be providing each services, and shall be signed by the client or the client's authorized representative, where appropriate, and the IHSS agency.

8.552.2 ELIGIBILITY

8.552.2.A. To be eligible for IHSS a client shall:

1. Be found eligible for either the Home or Community Based Services - Elderly Blind and Disabled (HCBS-EBD) or Children's Waiver; and

2. Provide a statement from his/her primary physician stating that the client or client's guardian has sound judgment and the ability to self direct care or the client has an authorized representative who has the judgment and ability to assist in acquiring and using services. For a client with an unstable medical condition, the physician's statement shall include a recommendation regarding whether additional in-home monitoring is necessary and if so, the amount and scope of the in-home monitoring.

8.552.2.B. A client shall no longer be eligible when:

1. The client is no longer eligible for either the Home or Community Based Services - Elderly Blind and Disabled or Children's Waiver.

2. The client's medical condition deteriorates causing an unsafe situation as documented by the primary physician.

3. The client refuses to designate an authorized representative if the client is unable to direct his/her own care as documented by the primary physician.

8.552.3 CLIENT RIGHTS AND RESPONSIBILITIES

8.552.3.A. A client or client's authorized representative has the right to:

1. Present a person(s) of his/her own choosing to the IHSS agency as a potential attendant.

2. Train and schedule attendant(s) to meet his/her needs.

3. Dismiss attendants who are not meeting his/her needs.

8.552.4 PROVIDER ELIGIBILITY

8.552.4.A. The IHSS agency shall conform to all certification standards and procedures set forth at 10 C.C.R. 2505-10, Section 8.487 and shall meet additional requirements set forth in 8.552.5.

8.552.4.B. The IHSS agency may be terminated from participation in the program pursuant to 10 C.C.R. 2505-10, Section 8.076.

8.552.5 PROVIDER RESPONSIBILITIES

8.552.5.A. The IHSS agency shall offer peer counseling including, but not limited to cross-disability peer counseling, information and referral services and individual and systems advocacy to all clients.

8.552.5.B. The IHSS agency shall provide 24-hour back-up service to clients at any time a scheduled attendant is not available, whether the attendant's absence is anticipated or unforeseen.

8.552.5.C. The IHSS agency shall provide intake and orientation service to clients or authorized representatives who are new to IHSS. Orientation shall include instruction in the philosophy, policies and procedures of IHSS and information concerning client rights and responsibilities.

8.552.5.D. The IHSS agency shall assist the client in selecting an attendant, if needed.

8.552.5.E. The IHSS agency shall ensure that a current IHSS Plan is in the client's record and send the IHSS Plan to the appropriate single entry point agency case manager within five days after any change in the Plan.

8.552.5.F. The IHSS agency shall contract with or have on staff a licensed health care professional who is at the minimum a registered nurse. The health care professional shall provide oversight and monitoring of the following activities:

1. Verification and documentation of attendant skills and competency to perform IHSS and basic consumer safety procedures.

2. Counsel attendant staff on difficult cases and potentially dangerous situations.

3. Consult with the client, authorized representative or attendant in the event a medical issue arises.

4. Investigate complaints and critical incidents within 10 working days.

5. Assure that the attendant is following directives found in the IHSS Plan.

8.552.5.G. The IHSS agency shall assure and document that all attendants have received basic training in the provision of IHSS. In lieu of basic training, the IHSS agency's licensed professional may administer a skills validation test.

8.552.5.H. Attendant training shall include, but not be limited to:

1. Development of interpersonal skills focused on addressing the needs of persons with disabilities.

2. Overview of IHSS.

3. Instruction on basic first aid administration.

4. Instruction on safety and emergency procedures.

5. Instruction on infection control techniques, including universal precautions.

8.552.5.I. Training may be modified if an attendant demonstrates competence in a given area.

8.552.5.J. Training and skills validation shall be completed prior to service delivery unless waived by the client or authorized representative to prevent interruption in services. In no event shall the training

or skills validation be postponed for more than 30 days after services begin.

8.552.5.K. The IHSS agency shall allow the client or authorized representative to provide individualized attendant training that is specific to his/her own needs and preferences.

8.552.5.L. The IHSS agency shall provide functional skills training to assist clients and/or authorized representatives in developing skills and resources to maximize their independent living and personal management of health care.

8.552.5.M. The IHSS agency may discontinue IHSS to a client when:

1. Equivalent care in the community has been secured; or

2. The client has exhibited inappropriate behavior toward the attendant and the Department has determined that the IHSS agency has made adequate attempts at dispute resolution and dispute resolution has failed. Inappropriate behavior includes, but is not limited to, documented verbal, sexual and/or physical abuse.

8.552.5.N. The IHSS agency shall provide 30 days advance written notice to the client detailing the inappropriate behavior prior to discontinuing services. Upon provider discretion, the provider may allow the client and/or client representative to use the 30 day notice period to correct the problem.

8.552.5.O. The IHSS agency shall send a copy of the 30 day written discontinuation notice to the single entry point case manager the same day the notice is sent to the client.

8.552.6 SINGLE ENTRY POINT RESPONSIBILITIES

8.552.6.A. The single entry point case manager shall ensure cost effectiveness and non-duplication of services by:

1. Documenting the discontinuation of previously authorized long-term home health services that shall be replaced by IHSS.

2. Documenting for new clients the long-term home health services that are available in lieu of IHSS.

3. Documenting and justifying any need for both long-term home health services and IHSS.

4. Ensuring all required information is in the client’s IHSS Plan.

5. Authorizing cost effective and non-duplicative services via the prior authorization request (PAR).

6. Reviewing the IHSS PAR and giving approval prior to services rendered. The PAR shall include the IHSS Plan delineating the services to be provided, the physician's statement, the authorized representative's signed statement when appropriate. The PAR shall include a dispute resolution process in the form of either a discharge policy or a client rights and responsibilities policy signed by the client.

8.552.7 REIMBURSEMENT

8.552.7.A. Reimbursement for IHSS shall occur only upon approval of the IHSS Care Plan and after the PAR has been submitted and approval received by the single entry point case manager.

8.552.7.B. For IHSS personal care and homemaker services, the reimbursement rate shall be the same

as for personal care and homemaker services under the HCBS-EBD Waiver set forth at 10 C.C.R. 2505-10 Section 8.489.

8.552.7.C. For IHSS Health Maintenance Activities the reimbursement rate shall be a blended average equal to 1/8th of a two-hour home health aid visit. The unit of service shall be 15 minutes.

8.553 COMMUNITY TRANSITION SERVICES

8.553.1 DEFINITIONS

Authorization Request means a request submitted by the Transition Coordination Agency to the Single Entry Point agency to authorize payment for delivery of Community Transition Services.

Community Transition Services (CTS) means activities essential to move a client from a skilled nursing facility and establish a community-based residence.

Independent Living Core Services means information and referral services; independent living skills training; peer counseling, including cross-disability peer counseling; and individual and systems advocacy.

Transition Coordinator means a person employed by a Transition Coordination Agency to provide Transitional Case Management.

Transition Coordination Agency (TCA) means an agency that is certified by the Department to provide CTS and provides at least two Independent Living Core Services.

Transitional Case Management means case management exclusively supporting a client's transition from a skilled nursing facility to a community-based residence.

8.553.2 BENEFITS

8.553.2.A. CTS shall only be available to clients currently residing in a skilled nursing facility who are eligible for the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) waiver.

8.553.2.B. CTS shall only be for the benefit of the client and may include the following:

1. Transitional Case Management.

2. Payment made for the following:

    a. Security deposits that are required to obtain a lease on a residence.

    b. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water.

    c. Essential household items and furnishings such as a bed, linens, seating, lighting, dishes, utensils and food preparation items.

    d. Moving expenses required to occupy a community-based residence.

    e. Health and safety assurances including a one-time pest eradication and a one-time cleaning prior to occupancy.

    f. A one-time purchase of food not to exceed $100.

8.553.2.C. The cost of CTS shall not exceed $2,000 per client unless otherwise authorized by the Department.

8.553.2.D. Items purchased through CTS shall be the property of the client. The client may take the property with him or her in the event of a move to another residence.

8.553.3 NON-BENEFITS

8.553.3.A. CTS shall not include the following:

1. Monthly rental expenses or other ongoing periodic residential expenses.

2. Recreation, entertainment or convenience items.

3. Items as described in 8.553.2.B.2 when already provided through other means.

4. Items as described in 8.553.2.B.2 when provided for the benefit of persons other than the client.

8.553.4 TCA QUALIFICATIONS

8.553.4.A. A TCA shall conform to all certification standards and procedures described in 10 C.C.R. 2505-10, Section 8.487, HCBS-EBD Provider Agencies.

8.553.4.B. A TCA shall meet all requirements as set forth in 8.553.5.

8.553.5 TCA RESPONSIBILITIES

8.553.5.A. TCAs shall administer the CTS benefit.

8.553.5.B. The TCA shall perform administrative functions, including ensuring timely reporting, on-site visits to clients, community coordination and outreach and client monitoring.

8.553.5.C. Staffing Requirements

1. The TCA shall document that each Transition Coordinator has received 20 hours of training or passed a Department-approved skills validation test in transition coordination knowledge and skills. The Transition Coordinator training or skills validation test shall include, but not be limited to:

    a. Knowledge of populations served by the TCA and the target population served by the HCBS-EBD waiver.

    b. Client interviewing and assessment skills.

    c. Intervention and interpersonal communication skills.

    d. Knowledge of available community resources and public assistance programs.

    e. Transition plan development.

2. The TCA supervisor(s), at a minimum, shall meet all qualifications for a Transition Coordinator. Supervision shall include, but not be limited to, the following activities:

    a. Arrangement and documentation of training or skills validation testing.

b. Assessment of client's satisfaction with services.

c. Investigation of complaints.

d. Counseling with staff on difficult cases.

e. Oversight of record keeping by staff.

3. Training and skills validation shall be completed prior to the delivery of CTS.

8.553.5.D. The Transition Coordinator shall administer a Department-approved assessment to determine the client's needs for housing, services and items necessary to establish a community-based residence.

8.553.5.E. The Transition Coordinator shall work with the client to create and implement a transition plan agreed upon by the Transition Coordinator and the client. The Transition Coordinator and the client shall sign the transition plan to signify agreement.

1. The Transition Coordinator shall submit the signed transition plan to the client's Single Entry Point (SEP) case manager for approval prior to plan implementation.

2. The plan shall include the items needed for the client to transition to a community-based residence. If after the plan has been approved the Transition Coordinator determines additional purchases are required, the Transition Coordinator shall submit a plan revision for approval prior to the purchases.

8.553.5.F. The Transition Coordinator shall work with the client to obtain a residence and any items necessary to establish a community-based residence.

8.553.5.G. The Transition Coordinator shall conduct a minimum of four on-site visits of the residence to ensure all essential furnishings, utilities, community resources and services are in place. If the Transition Coordinator finds any of the supports to be insufficient for the client to successfully live in the community, the Transition Coordinator shall correct the deficiencies. The on-site visits shall occur at the following intervals:

1. Prior to the client's discharge from the skilled nursing facility.

a. If possible, the client shall accompany the Transition Coordinator during the on-site visit prior to discharge. If the client is unable to participate in the on-site visit, the Transition Coordinator shall document the reason in the client's file.

2. The day of the move.

3. One week after the transition to ensure the client has the proper supports to continue successfully living in the community.

4. One month after the transition to ensure the client has the proper supports to continue successfully living in the community.

8.553.6 SINGLE ENTRY POINT AGENCY RESPONSIBILITIES

8.553.6.A. The SEP case manager shall perform a review to assure all items in the transition plan meet the criteria of the benefit described in 8.553.2.

1. The SEP case manager shall complete a review of the transition plan and shall notify the TCA

of approval or denial of the plan within ten business days of receipt.

8.553.7 AUTHORIZATION REQUESTS

8.553.7.A. The TCA shall submit the Department prescribed Authorization Request (AR) form to the SEP case manager to authorize payment for CTS.

1. The TCA shall only submit the AR to authorize payment for any purchases or deposits after the client transitions to the community. The AR shall include a Department-approved cost report including copies of cancelled checks and copies of receipts detailing the items purchased and the cost.

    a. Any expenses submitted on the cost report for items that are not included in the approved transition plan shall be considered non-allowable expenses and shall not be reimbursed.

    b. The SEP case manager shall complete a review of the AR and the cost report and shall notify the TCA of approval or denial of the AR and if applicable, any non-allowable expenses on the cost report within ten business days of receipt.

2. The TCA shall only submit the AR for Transitional Case Management once the Transition Coordinator has conducted the on-site visit one month after the client's transition.

    a. The SEP case manager shall approve the AR only after verifying that the client is established in a community-based residence.

    b. The SEP case manager shall complete a review of the AR and shall notify the TCA of approval or denial within ten business days of receipt.

8.553.7.B. The SEP case manager shall complete a review of the AR and the cost report within ten business days of receipt. The SEP case manager shall notify the TCA of approval of the AR and if applicable, any non-allowable expenses on the cost report.

1. Approval of the AR by the SEP case manager shall authorize the TCA to submit claims to the Department's fiscal agent for authorized CTS provided during the authorized period. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the TCA's use of correct billing procedures.

8.553.7.C. Incomplete ARs shall be returned to the TCA for correction within ten business days of receipt by the SEP agency.

8.553.8 REIMBURSEMENT

8.553.8.A. The TCA shall conform to all reimbursement procedures described in 10 C.C.R. 2505-10, Section 8.487.200 Provider Reimbursement.

8.553.8.B. Payment for CTS shall be the lower of the billed charges or the maximum rate of reimbursement.

8.553.8.C. The cost of Transitional Case Management shall be reimbursed by one unit of service completed when the client is established in a community-based residence as verified by the SEP case manager.

8.553.8.D. Reimbursement shall be made only for items listed on the transition plan with an accompanying receipt.

8.560 CLINIC SERVICES – CERTIFIED HEALTH AGENCIES

Clinic Services rendered by certified health agencies shall be a benefit of the Colorado Medical Assistance Program for categorically eligible individuals.

8.560.1 DEFINITIONS

For the purposes of this Section 8.560, the following definitions shall apply:

A. Certified health agency: a county/district health department, regional health department or local board of health established pursuant to part 5, 6, or 7 of article 1 of title 25, C.R.S., that is certified by the Colorado State Department of Health.

B. Nurse/Nurse practitioner: a registered professional nurse who is currently licensed to practice in the State of Colorado and who meets the qualifications established by the Nurse Practice Act.

C. Nurse-midwife: a registered professional nurse currently licensed to practice in the State of Colorado who meets the following requirements: is certified as a nurse-midwife by the American College of Nurse-Midwives; is authorized under state statute to practice as a nurse-midwife; and whose services are rendered pursuant to the Colorado Medical Practice Act.

D. Physician assistant/child health associate: a certified individual who performs under the supervision of a physician and meets the qualifications of the Colorado State Board of Medical Examiners.

E. Physician: a doctor of medicine, osteopathy, legally authorized to provide medicine or surgery in Colorado.

F. Medicaid primary care physician: a physician enrolled in the Primary Care Physician Program under the Colorado Medical Assistance Program.

G. Visit: a face-to-face encounter between a clinic patient and nurse/nurse practitioner/nurse-midwife, physician assistant/child health associate, or physician providing services reimburseable under the Medicaid Program. If a patient sees more than one health professional, or meets more than once with the same health professional, on the same day and at a single location, this shall be counted as one visit.

8.561 REQUIREMENTS FOR CERTIFICATION

A. Participating health agencies must be certified by the Colorado State Department of Health in accord with federal regulations 42 CFR 431.610, October 1991 edition. No amendments or later editions are incorporated. Copies are available for inspection and available at cost at the following address: Manager, Health and Medical Services, Colorado Department of Social Services, 1575 Sherman Street, Denver, Colorado 80203-1714. Certified health agencies performing laboratory services must be certified as a clinical laboratory in accordance with regulations cited at 8.660 through 8.666. Certified health agencies must obtain a certificate of waiver from the Health Care Financing Administration or its designated agency if the health agency only performs waivered tests as defined by Clinical Laboratory Improvement Amendments of 1988 (CLIA).

B. All certified health agencies and staff shall comply with all applicable federal, state and local regulations concerning the operation of such clinic services. These include but are not limited to the following: certification, organization, staffing, licensure of personnel, service provision responsibilities, maintenance of health records and program evaluation.

C. Termination of certification or non-renewal of certification will be determined by the Colorado State Department of Health.

8.562 REQUIREMENTS FOR PARTICIPATION

Health agencies providing clinic services must be certified by the Colorado State Department of Health, must enroll in the Medical Assistance Program and provide proof of their certification status in order to participate under Medicaid. The certification document must be attached to the Medical Assistance enrollment form. Medical Assistance enrollment and/or reimbursement cannot be accomplished without proof of certification on file with the State's fiscal agent for the effective date of enrollment and date of service for which reimbursement is claimed.

8.563 BENEFITS AND LIMITATIONS

Clinic Services are a benefit of the Medical Assistance Act in Colorado when:

A. The services are benefits of the Colorado Medicaid Program as determined by the Colorado State Department of Social Services;

B. The services which are performed are medically necessary;

C. The services are provided by certified health agencies;

D. The services which are performed are within the scope of the providers' Medical and/or Nurse Practice Acts;

E. The services are provided by a registered nurse, qualified nurse practitioner, or certified nurse-midwife or by a physician or physician's assistant (including child health associates) certified by the Colorado State Board of Medical Examiners;

F. The services provided are obstetrical services which are benefits of the Medicaid program; or

G. The services provided are EPSDT medical screening services which meet the requirements set forth in sections 8.285.02 through 8.287.01.

8.564 BILLING PROCEDURES

A. Certified health agencies providing clinic services must bill the Medical Assistance Program directly using the designated billing method and the prescribed procedure codes recognized by the Colorado State Department of Social Services. The amount of the provider's usual and customary charges to the general public will be billed if applicable.

B. Obstetrical services and adjunctive services, except for EPSDT medical screenings, must be billed directly on the Colorado 1500 Claim Form.

C. EPSDT medical screening services must be billed directly on the EPSDT Screening/Claim Form.

8.565 REIMBURSEMENT

Reimbursement shall be made according to the following:

A. Payment for benefit services shall be in accord with the physician reimbursement policies as cited in Section 8.200.20.

B. Each certified health agency will be reimbursed for only those services performed for which it is certified and for only one visit per recipient per day.

C. Reimbursement for injectable vaccines obtained through the Infant Immunization Program is limited to

the maximum allowed administrative fee.

D. A health agency must be certified on any date for which reimbursement is being claimed. If reimbursement is claimed for a date of service on which the health agency is not certified, reimbursement shall be denied.

8.566 APPEALS

Provider grievances and appeals, resulting from State actions under this section of regulations, shall be handled in accordance with existing appeals regulations delineated in Sections 8.049 through 8.051.44.

8.567 CERTIFIED HEALTH AGENCY/PHYSICIAN RELATIONSHIP

A. Obstetrical services require referral from the Medicaid Primary Care (PCP) or "Lock-In" physician. The certified agency will contact the PCP to obtain the appropriate referral for obstetrical services.

B. EPSDT medical screenings require referral from the Medicaid Primary Care (PCP) or "Lock-In" physician. The certified agency will contact the PCP to obtain the appropriate referral for EPSDT Medical screening services.

C. Medical support and approval for the policies and procedures of the local certified health agency's Well Child Clinics and Prenatal Clinics may be provided by the agency health officer, medical director or other physician (pediatrician, family practitioner or obstetrician) agreed upon by the public health nursing staff and their health officer. A physician must sign and annually review the agency's emergency procedures for reactions to biologicals.

D. The certified health agency shall assure that a physician is available during agency hours by direct means of communication for assistance in emergencies and for consultation and referral if medical diagnosis and/or treatment is needed. This requirement may be satisfied by agreements with one or more physicians. Whenever possible, the certified health clinic practitioner will interact with the client's primary care physician when medical consultation is needed and will provide the primary care physician a copy of each EPSDT medical screening and obstetrical service record.

8.570 AMBULATORY SURGERY CENTERS

8.570.1 DEFINITION

Ambulatory Surgery Center (ASC) means an entity that operates exclusively for the purpose of furnishing surgical procedures for its clients that do not require hospitalization. An ASC may be part of a hospital, but only if the building space utilized by the ASC is physically separated from any other health services offered by a hospital.

8.570.2 REQUIREMENTS FOR PARTICIPATION

8.570.2.A. An ASC shall be certified by the Center for Medicare and Medicaid Services (CMS) to participate in the Medicare program as an ASC and be licensed by the Colorado Department of Public Health and Environment.

8.570.3 COVERED SERVICES

8.570.3.A. Covered services are those surgical and other medical procedures that:

1. Are ASC procedures that are grouped into categories corresponding to the CMS defined groups.

2. Are commonly performed on an inpatient basis in hospitals, but may be safely performed in an ASC.

3. Are limited to those requiring a dedicated operating room (or suite), and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room.

8.570.3.B. Covered surgical procedures are limited to those that do not generally exceed:

1. A total of 90 minutes operating time.

2. A total of 4 hours recovery or convalescent time.

8.570.3.C. If the covered surgical procedures require anesthesia, the anesthesia must be:

1. Local or regional anesthesia; or

2. General anesthesia of 90 minutes or less duration.

8.570.4 NON-COVERED SERVICES

8.570.4.A Non-covered services are those services that:

1. Are not commonly performed or may safely be performed in a physicians office;

2. Generally result in extensive blood loss:

3. Require major or prolonged invasion of body cavities;

3. Directly involve major blood vessels; or

4. Are generally emergency or life-threatening in nature.

8.570.5 ALLOWABLE COSTS

8.570.5.A The services payable under this rule are facility services furnished to clients in connection with covered surgical procedures specified in Section 8.570.3.

1. Services and items reimbursed as part of the facility fee include, at a minimum, the following:

a. Use of the facilities where the surgical procedures are performed.

b. Nursing, technician, and related services.

c. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures.

d. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure.

e. Administrative, record keeping and housekeeping items and services.

f. Materials for anesthesia.

g. Intra-ocular lenses (IOLs).

h. Supervision of the services of an anesthetist by the operating surgeon.

2. Services and items that are not reimbursed as part of the facility fee, but that may be reimbursed separately include the following:

a. Physician services.

b. Anesthetist services.

c. Laboratory, X-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure.)

d. Prosthetic devices (except IOLs).

e. Ambulance services.

f. Leg, arm, back and neck braces.

g. Artificial limbs.

h. Durable medical equipment for use in the client's home.

8.570.6 REIMBURSEMENT

8.570.6.A For payment purposes, ASC surgical procedures are grouped into nine categories corresponding to CMS defined groups. The Health Care Procedural Coding System (HCPCS) is used to identify surgical services.

8.570.6.B Reimbursement for approved surgical procedures shall be allowed only for the primary or most complex procedure. No reimbursement is allowed for multiple or subsequent procedures. Approved surgical procedures identified in one of the nine ASC groupers shall be reimbursed a facility fee at the lower of billed charges or 80% of the Medicare assigned rate. No reimbursement shall be allowed for services not included on the Department approved list for covered services.

8.571 CLINIC SERVICES - AMBULATORY SURGERY CENTER, PHYSICIAN PRIOR AUTHORIZATION

The physician performing the surgery shall be responsible for obtaining all necessary Prior Authorizations for those procedures requiring pre-procedure approval by the Department.

8.580 OXYGEN AND OXYGEN EQUIPMENT

8.580.1 OXYGEN AND OXYGEN EQUIPMENT PROVIDED IN CLIENT HOMES

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.

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.

8.580.2 OXYGEN, AND OXYGEN EQUIPMENT, PROVIDED TO HOSPITAL CLIENTS

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.

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.

8.580.3 OXYGEN, AND OXYGEN EQUIPMENT PROVIDED TO NURSING HOME CLIENTS

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.

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.

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.

8.580.3.F. The nursing facility shall provide the following information to the oxygen provider within 20 days following the date the provider delivers the equipment and supplies to the facility.

1. The name and state identification number for all clients provided liquid or gaseous oxygen, or the equipment and supplies needed for its administration.

2. Evidence that Medicare Part A or Part B or other third party resources are available or unavailable.

3. The name and state identification number for all clients utilizing an oxygen concentrator, rented from the oxygen supplier, who reside in a facility not providing facility-owned concentrators.

4. A statement guaranteeing that equipment, supplies, and oxygen were used only by the client for whom they were supplied.

5. In the case of a facility utilizing centralized oxygen systems, specific client oxygen usage, expressed in liters.

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.

8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff*

12/31/2006]

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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: *[Eff 12/31/2006]*

1. Be prescribed by a physician and when applicable, be recommended by an appropriately licensed practitioner. *[Eff 12/31/2006]*

2. Be a reasonable, appropriate and effective method for meeting the client's medical need. *[Eff 12/31/2006]*

3. Have an expected use that is in accordance with current medical standards or practices. *[Eff 12/31/2006]*

4. Be cost effective, which means that less costly and medically appropriate alternatives do not exist or do not meet treatment requirements. *[Eff 12/31/2006]*

5. Provide for a safe environment. *[Eff 12/31/2006]*

6. Not be experimental or investigational, but generally accepted by the medical community as standard practice. *[Eff 12/31/2006]*

7. Not have as its primary purpose the enhancement of a client's personal comfort or to provide convenience for the client or caretaker. *[Eff 12/31/2006]*

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: *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.2.E. Rental equipment shall be provided if the Department determines it to be cost effective and Medically Necessary. *[Eff 12/31/2006]*

8.590.2.F. Supplies shall be for a specific purpose, not incidental or general purpose usage. *[Eff 12/31/2006]*

8.590.2.G. The following DME and Supplies are benefits for clients regardless of age: *[Eff 12/31/2006]*

1. Ambulation devices and accessories including but not limited to canes, crutches or walkers. *[Eff 12/31/2006]*

2. Bath and bedroom safety equipment. *[Eff 12/31/2006]*

3. Bath and bedroom equipment and accessories including, but not limited to, specialized beds and mattress overlays. *[Eff 12/31/2006]*

4. Manual or power Wheelchairs and accessories. *[Eff 12/31/2006]*

5. Diabetic monitoring equipment and related disposable supplies. *[Eff 12/31/2006]*

6. Elastic supports/stockings. *[Eff 12/31/2006]*

7. Blood pressure, apnea, blood oxygen, Pacemaker and uterine monitoring equipment and supplies. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

9. Transcutaneous and/or neuromuscular electrical nerve stimulators (TENS/NMES) and related supplies. *[Eff 12/31/2006]*

10. Trapeze, traction and fracture frames. *[Eff 12/31/2006]*

11. Lymphedema pumps and compressors. *[Eff 12/31/2006]*

12. Specialized use rehabilitation equipment. *[Eff 12/31/2006]*

13. Oral and enteral formulas and supplies. *[Eff 12/31/2006]*

14. Parenteral equipment and supplies. *[Eff 12/31/2006]*

15. Environmental controls for a client living unattended if the controls are needed to assure medical safety. *[Eff 12/31/2006]*

16. Facilitative Devices. *[Eff 12/31/2006]*

    a. Telephone communication devices for the hearing impaired and other facilitative

listening devices, except hearing aids, and cochlear implants. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

c. Computer equipment with voice output, artificial larynges, voice amplification devices and other alternative and augmentative communication devices. *[Eff 12/31/2006]*

d. Voice recognition computer equipment software and hardware and other forms of computers for persons with disabilities. *[Eff 12/31/2006]*

e. Any other device that enables a person with a disability to communicate, see, hear or maneuver including artificial limbs and orthopedic footwear. *[Eff 12/31/2006]*

8.590.2.H. The following DME are benefits to clients under the age of 21: *[Eff 12/31/2006]*

1. Hearing aids and accessories. *[Eff 12/31/2006]*

2. Phonic ear. *[Eff 12/31/2006]*

3. Therapy balls for use in physical or occupational therapy treatment. *[Eff 12/31/2006]*

4. Selective therapeutic toys. *[Eff 12/31/2006]*

5. Computers and computer software when utilization is intended to meet medical rather than educational needs. *[Eff 12/31/2006]*

6. Vision correction unrelated to eye surgery. *[Eff 12/31/2006]*

8.590.2.I. The following Prosthetic or Orthotic Devices are benefits for clients regardless of age: *[Eff 12/31/2006]*

1. Artificial limbs. *[Eff 12/31/2006]*

2. Facial Prosthetics. *[Eff 12/31/2006]*

3. Ankle-foot/knee-ankle-foot orthotics. *[Eff 12/31/2006]*

4. Recumbent ankle positioning splints. *[Eff 12/31/2006]*

5. Thoracic-lumbar-sacral orthoses. *[Eff 12/31/2006]*

6. Lumbar-sacral orthoses. *[Eff 12/31/2006]*

7. Rigid and semi-rigid braces. *[Eff 12/31/2006]*

8. Therapeutic shoes. *[Eff 12/31/2006]*

9. Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements. *[Eff 12/31/2006]*

10. Specialized eating utensils and other medically necessary activities of daily living aids. *[Eff 12/31/2006]*

11. Augmentative communication devices and communication boards. *[Eff 12/31/2006]*

8.590.2.J. Repairs and replacement parts are covered under the following conditions: *[Eff 12/31/2006]*

1. The item was purchased by Medicaid; or *[Eff 12/31/2006]*

2. The item is owned by the client, client's family or guardian; and *[Eff 12/31/2006]*

3. The item is used exclusively by the client; and *[Eff 12/31/2006]*

4. The item's need for repair was not caused by client misuse, abuse or neglect; and *[Eff 12/31/2006]*

5. The item is no longer under the manufacturer warranty. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.2.M. Supplies are a covered benefit when related to the following: *[Eff 12/31/2006]*

1. Surgical, wound or burn care. *[Eff 12/31/2006]*

2. Syringes or needles. *[Eff 12/31/2006]*

3. Bowel or bladder care. *[Eff 12/31/2006]*

4. Antiseptics or solutions. *[Eff 12/31/2006]*

5. Gastric feeding sets and supplies. *[Eff 12/31/2006]*

6. Tracheostomy and endotracheal care supplies. *[Eff 12/31/2006]*

7. Diabetic monitoring. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.2.P. Items used for the following are not a benefit to a client of any age: *[Eff 12/31/2006]*

1. Routine personal hygiene. *[Eff 12/31/2006]*

2. Education. *[Eff 12/31/2006]*

3. Exercise. *[Eff 12/31/2006]*

4. Participation in sports. *[Eff 12/31/2006]*

5. Client or caretaker convenience. *[Eff 12/31/2006]*

6. Cosmetic purposes. *[Eff 12/31/2006]*

7. Personal comfort. *[Eff 12/31/2006]*

8.590.2.Q. For clients age 21 and over, the following items are not a benefit: *[Eff 12/31/2006]*

1. Hearing aids and accessories. *[Eff 12/31/2006]*

2. Phonic ears. *[Eff 12/31/2006]*

3. Therapeutic toys. *[Eff 12/31/2006]*

4. Vision correction unrelated to eye surgery. *[Eff 12/31/2006]*

8.590.2.R. Rental Policy. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

3. The rental period may be interrupted, for a maximum of sixty consecutive days. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

5. If the client changes providers, the current rental cap remains in force. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.3.B. Prior authorization shall not be required for Medicare Crossover claims. *[Eff 12/31/2006]*

8.590.3.C. Prior authorization shall be required for clients who have other primary insurance besides Medicare. *[Eff 12/31/2006]*

8.590.3.D. Prior authorization requests shall include the following information: *[Eff 12/31/2006]*

1. A full description of the item(s). *[Eff 12/31/2006]*

2. The requested number of items. *[Eff 12/31/2006]*

3. A full description of all attachments, accessories and/or modifications needed to the basic item(s). *[Eff 12/31/2006]*

4. The effective date and estimated length of time the item(s) will be needed. *[Eff 12/31/2006]*

5. The diagnosis, prognosis, previous and current treatments and any other clinical information necessary to establish Medical Necessity for the client. *[Eff 12/31/2006]*

6. Any specific physical limitations the client may have that are relevant to the prior authorization consideration. *[Eff 12/31/2006]*

7. The client's prescribing physician's, primary care physician's and provider's name and identification numbers. *[Eff 12/31/2006]*

8. The serial numbers for all Wheelchair repairs. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.4.B. The Provider shall implement and maintain a process for honoring all warranties expressed and implied under applicable State laws. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.4.D. Providers shall maintain the following for all items provided to a client: *[Eff 12/31/2006]*

1. Physician prescriptions. *[Eff 12/31/2006]*

2. Approved prior authorization requests. *[Eff 12/31/2006]*

3. Additional documentation received from physicians or other licensed practitioners. *[Eff 12/31/2006]*

4. Documentation that the client and/or caregiver have been provided with the following: *[Eff 12/31/2006]*

    a. Manufacturer's instructions. *[Eff 12/31/2006]*

    b. Warranty information. *[Eff 12/31/2006]*

    c. Registration documents. *[Eff 12/31/2006]*

    d. Service manual. *[Eff 12/31/2006]*

    e. Operating guides. *[Eff 12/31/2006]*

5. Documentation on all reimbursed equipment, which shall include: *[Eff 12/31/2006]*

    a. Manufacturer's name and address. *[Eff 12/31/2006]*

    b. Date acquired. *[Eff 12/31/2006]*

    c. Acquisition cost. *[Eff 12/31/2006]*

    d. Model number. *[Eff 12/31/2006]*

    e. Serial number. *[Eff 12/31/2006]*

    f. Accessories, attachments or special features included in the item. *[Eff 12/31/2006]*

6. Providers shall verify that equipment requiring repairs belongs to the presenting client. *[Eff 12/31/2006]*

8.590.4.E. Providers shall retain all documentation for a period of six years. *[Eff 12/31/2006]*

8.590.4.F. Providers shall provide a copy of all documentation to a client or his/her representative, if requested. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.4.J. Providers shall confirm continued need for disposable supplies with the client or caretaker prior to supply shipment. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.4.N. The following requirements shall apply to warranted items: *[Eff 12/31/2006]*

1. The provider shall be able to provide adequate repairs, adjustments and services by appropriately trained technicians for all products they distribute. *[Eff 12/31/2006]*

2. The provider shall complete services or repairs in a timely manner and advise the client on the estimated completion time. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.4.P. The Provider shall assure the item provided meets the following conditions: *[Eff 12/31/2006]*

1. The item is fully serviced and reconditioned. *[Eff 12/31/2006]*

2. The item is functionally sound and in good operating condition. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.4.R. The provider shall assure the following for rental equipment: *[Eff 12/31/2006]*

1. Appropriate service to the item. *[Eff 12/31/2006]*

2. Complete services or repairs in a timely manner with an estimate of the approximate time required. *[Eff 12/31/2006]*

3. Appropriate alternative equipment during repairs. *[Eff 12/31/2006]*

4. Provision and replacement of all expendable items, including but not limited to hoses, fuses, and batteries. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.5.B. The above providers must also have: *[Eff 12/31/2006]*

1. A street address; and *[Eff 12/31/2006]*

2. A local business telephone number; *[Eff 12/31/2006]*

3. An inventory; and *[Eff 12/31/2006]*

4. Sufficient staff to service or repair products. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

2. Applications submitted pursuant to this section will be reviewed for approval on a case-by-case basis for those specialty items only. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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: *[Eff 12/31/2006]*

1. The cost of the items. *[Eff 12/31/2006]*

2. That the client was not coerced into purchasing the items. *[Eff 12/31/2006]*

3. That the client is fully responsible for the cost, servicing and repairs to the items after the warranty period is completed. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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: *[Eff 12/31/2006]*

1. Cleaning and lubricating moving parts. *[Eff 12/31/2006]*

2. Adding water to batteries. *[Eff 12/31/2006]*

3. Checking tire pressure. *[Eff 12/31/2006]*

4. Other prescribed Manufacturer procedures. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.6.I. The client shall not remove rental equipment from Colorado. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.7.C. The provider shall credit the cost of any accessory or part removed from a standard package to the Department. *[Eff 12/31/2006]*

8.590.7.D. Charges submitted for modifications that require the provider to provide them from their own inventory or stock shall be supported as to the necessity and actual cost of those modifications. *[Eff 12/31/2006]*

8.590.7.E. 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. *[Eff 12/31/2006]*

8.590.7.F. The refund amount due the Department on a returned Wheelchair or Facilitative Device shall be agreed upon by the dealer or manufacture; wherever the item was returned, and the Department. *[Eff 12/31/2006]*

8.590.7.G. Reimbursement for used equipment shall include: *[Eff 12/31/2006]*

1. A written, signed and dated agreement from the client accepting the equipment. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

8.590.7.H. Reimbursement for purchased or rented equipment shall include, but is not limited to: *[Eff 12/31/2006]*

1. All elements of the manufacturer's warranties or express warranties. *[Eff 12/31/2006]*

2. All adjustments and modification needed by the client to make the item useful and functional. *[Eff 12/31/2006]*

3. Delivery, set-up and installation of equipment in the home, and if appropriate to a specific room in the home. *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

5. Training and instruction on the manufacturer's instructions, servicing manuals and operating guides. *[Eff 12/31/2006]*

8.590.7.I. Reimbursement rate for a purchased item shall be as follows: *[Eff 12/31/2006]*

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. *[Eff 12/31/2006]*

2. Manually priced items that have no maximum allowable reimbursement rate assigned shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturers invoice cost, plus twenty percent. *[Eff 12/31/2006]*

8.590.7.J. Reimbursement for rental items shall be billed and paid in monthly increments unless otherwise indicated in the Medicaid Bulletin. *[Eff 12/31/2006]*

8.590.7.K. Reimbursement for clients eligible for both Medicare and Medicaid shall be made in the following manner: *[Eff 12/31/2006]*

1. The provider shall bill Medicare first unless otherwise authorized by the Department. *[Eff 12/31/2006]*

2. If Medicare makes payment, Medicaid reimbursement will be based on appropriate deductibles and co-payments. *[Eff 12/31/2006]*

3. If Medicare denies payment, the provider shall be responsible for billing the Department. Reimbursement is dependent upon the following conditions: *[Eff 12/31/2006]*

    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 *[Eff 12/31/2006]*

    b. Medicaid reimbursement shall not be made if the Medicare denial is based upon provider submission error. *[Eff 12/31/2006]*