

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE – SECTION 8.200 Physician Services, Dental, Vision Services, Medicaid Managed Care Program, EPSDT

10 CCR 2505-10 8.200

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

8.200 PHYSICIAN SERVICES

8.200.1.A Definitions

1. Advanced Practice Nurse means a provider that meets the requirements to practice advanced practice nursing as defined in Article 38 of Title 12 of the Colorado Revised Statutes. In Colorado an Advanced Practice Nurse may have prescriptive authority.
2. Certified Family Planning Clinic means a family planning clinic certified by the Colorado Department of Public Health and Environment, accredited by a national family planning organization and staffed by medical professionals licensed to practice in the State of Colorado, including but not limited to, doctors of medicine, doctors of osteopathy, physicians' assistants, and advanced practice nurses.
3. Direct Supervision means the supervising provider shall be on-site during the rendering of services and immediately available to give assistance and direction throughout the performance of the service.
4. General Supervision means the supervising provider may not be on-site during the rendering of services, but is immediately available via telephonic or other electronic means to give assistance and direction throughout the performance of the service. Health Education Services means the provision of counseling, referral, instruction, suggestions, and support to maintain or improve health.
5. Licensed Psychologist means a provider that meets the requirements to practice psychology as defined in Part 3 of Article 43 of Title 12 of the Colorado Revised Statutes.
6. Medical Necessity is defined in Section 8.076.1.8.

8.200.2 Providers

- 8.200.2.A. A doctor of medicine or a doctor of osteopathy may order and provide all medical care goods and services within the scope of their license that are covered benefits of the Colorado Medical Assistance Program.
1. A provider of covered dental care surgery may be enrolled as either a dentist or oral surgeon, but not as both. A dentist may order and provide covered dental care.
- 8.200.2.B. Physician services that may be provided by non-physician providers without a physician order.

1. Advanced Practice Nurses may provide and order covered goods and services in accordance with the scope of practice as described in the Colorado Department of Regulatory Agencies rules without a physician order.
 2. Licensed Psychologists may provide and order covered mental health goods and services in accordance with the scope of practice as described in the Colorado Department of Regulatory Agencies rules without a physician order.
 - a. Services ordered by a Licensed Psychologist but rendered by a non-licensed mental health provider must be signed and dated by the Licensed Psychologist contemporaneously with the rendering of the service by a non-licensed mental health provider.
 3. Optometrists may provide covered optometric goods and services within their scope of practice as described by the Colorado Department of Regulatory Agencies rules without a physician order.
 4. Podiatrists may provide covered foot care services within their scope of practice as described by the Colorado Department of Regulatory Agencies rules without a physician order.
 5. Licensed dental hygienists may provide unsupervised covered dental hygiene services in accordance with the scope of practice for dental hygienists as described in the Colorado Department of Regulatory Agencies rules without a physician order.
 6. Licensed pharmacists may provide covered services, in accordance with the scope of practice for pharmacists as described by the Colorado Department of Regulatory Agencies rules, without a physician order.
- 8.200.2.C. Physician services that may be provided by a non-physician provider when ordered by a provider acting under the authority described in Sections 8.200.2.A. and 8.200.2.B.
1. Registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, and licensed physician assistants may provide services ordered by a physician.
 - a. Services must be rendered and supervised in accordance with the scope of practice for the non-physician provider described in the Colorado Department of Regulatory Agencies rules.
- 8.200.2.D. Physician services that may be provided by a non-physician provider when supervised by an enrolled provider.
1. With the exception of the non-physician providers described in Sections 8.200.2.A. through 8.200.2.C. and 8.200.2.D.1.a., a non-physician provider may provide covered goods and services only under the Direct Supervision of an enrolled provider who has the authority to supervise those services, according to the Colorado Department of Regulatory Agencies rules. If Colorado Department of Regulatory Agencies rules do not designate who has the authority to supervise, the non-physician provider must provide services under the Direct Supervision of an enrolled physician.
 - a. Registered Nurses (RNs) are authorized to provide delegated medical services within their scope of practice as described in the Colorado Department of Regulatory Agencies rules under General Supervision.

- b. Non-physician providers are authorized to provide Health Education Services under General Supervision of a provider who has the authority to supervise them in accordance with Colorado Department of Regulatory Agencies rules.
- c. Physical therapy assistants, occupational therapy assistants, and speech language pathology clinical fellows are authorized to provide services within their scope of practice, and under the General Supervision of an enrolled provider who has the authority to supervise them, in accordance with Colorado Department of Regulatory Agencies rules.
- d. Speech language pathology assistants are authorized to provide services within their scope of practice only under the Direct Supervision of a licensed speech language pathologist who has the authority to supervise them, in accordance with Colorado Department of Regulatory Agencies rules

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

8.200.3. BENEFITS

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

- 1. Physician services in dental care are a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fraction of the jaw or facial bones. Service includes dental splints or other devices.
- 2. Outpatient mental health services are provided as described in Section 8.212.
- 3. Physical examinations are a benefit when they meet the following criteria:
 - a. Physical examinations are a benefit for preventive service, diagnosis and evaluation of disease or early and periodic screening, diagnosis and treatment for clients under the age of 21 as described in Section 8.280.
 - b. Physical examination as a preventive service for adults is a benefit limited to one per state fiscal year.
- 4. Physician services for the provision of immunizations are a benefit. Vaccines provided to enrolled children that are eligible for the Vaccines for Children program shall be obtained through the Colorado Department of Public Health and Environment. Immunization services are provided in accordance with Section 8.815.
- 5. Physician services for laboratory testing described in Section 8.660, are a benefit.
- 6. Occupational and physical therapy services are benefits.
- 7. Family planning services described in Section 8.730 are benefits.

8.200.3.B Physician services may be provided as telemedicine in accordance with Section 8.095.

8.200.3.C Services and goods generally excluded from coverage are identified in Section 8.011.11.

8.200.3.D Physician Services

Note: 8.200.3.D.1 Podiatry Services was moved to §8.810 01/2015.

2. Speech – Language and Hearing Services

a. ELIGIBLE PROVIDERS

- i. Eligible providers include individual practitioners and those employed by home care agencies, children's developmental service agencies, health departments, federally qualified health centers (FQHC), clinics, or hospital outpatient services.
- ii. Otolaryngologists, speech-language pathologists (speech therapists), and audiologists shall have a current and active license or registration and be current, active and unrestricted to practice.
- iii. Providers shall be enrolled as a Health First Colorado provider in order to be eligible to bill for procedures, products and services in treating a Health First Colorado client.
- iv. Rendering Providers include:
 1. Otolaryngologist
 2. Speech-language pathologist
 3. Speech-language pathology assistant
 4. Clinical fellows
 5. Audiologist

b. PROVIDER AGENCY REQUIREMENTS

- i. Providers of in-home health who employ therapists or audiologists shall apply for licensing through the Colorado Department of Public Health and Environment (CDPHE). (§25-27.5-103(1), C.R.S. and 6 CCR 1011-1, Chapter XXVI, Section 5.1) as a home care agency.
 1. This rule does not apply to providers delivering Early Intervention Services under an Individual Family Service Plan (IFSP) and billing through contracts with the Community Centered Boards.

c. ELIGIBLE PLACES OF SERVICE

- i. Eligible Places of Service shall include:
 1. Office
 2. Home
 3. School

- A. Therapies provided as part of a member's school requirement are not separately reimbursable. These services are paid for by the school district which is reimbursed by the Department. Providers may not submit claims for therapy services performed as part of a member's school requirement.
- 4. FQHC
- 5. Outpatient Hospital
- 6. Community Based Organization
- 7. Telemedicine in accordance with Section 8.095.
- d. ELIGIBLE CLIENTS
 - i. Eligible Clients include enrolled clients ages twenty (20) and under and adult clients who qualify under medically necessary services. Qualifying adult clients may receive services for non-chronic conditions and acute illness and injuries.
- e. COVERED SERVICES
 - i. Newborn Screening
 - 1. Screening shall include a comprehensive health assessment performed soon after birth or as early as possible in a child's life and repeated at periodic intervals of time as recommended by the Colorado Early & Periodic Screening & Diagnostic and Treatment (EPSDT) periodicity schedules.
 - ii. Early Language Intervention
 - 1. Early language intervention for children 0 through three with a hearing loss may be provided by audiologists, speech therapists, or Colorado Home Intervention Program (CHIP) providers.
 - iii. Audiology Services
 - 1. Audiological benefits include identification, diagnostic evaluation and treatment for children with hearing loss, neurologic, dizziness/vertigo, or balance disorders. Conditions treated may be either congenital or acquired.
 - 2. Assessment – Service may include testing or clinical observation or both, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report.
 - a. Auditory sensitivity (including pure tone air and bone conduction, speech detection and speech reception thresholds).
 - b. Auditory discrimination in quiet and noise.

- c. Impedance audiometry (tympanometry and acoustic reflex testing).
 - d. Hearing aid evaluation (amplification selection and verification).
 - e. Central auditory function.
 - f. Evoked otoacoustic emissions.
 - g. Brainstem auditory evoked response.
 - h. Assessment of functional communicative skills to enhance the activities of daily living.
 - i. Assessment for cochlear implants (for clients ages 20 and under).
 - j. Hearing screening.
 - k. Assessment of facial nerve function.
 - l. Assessment of balance function.
 - m. Evaluation of dizziness/vertigo.
3. Treatment – Service may include one or more of the following, as appropriate:
- a. Auditory training.
 - b. Speech reading.
 - c. Augmentative and alternative communication training including training on how to use cochlear implants for clients ages 20 and under. Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of Activities of Daily Living.
 - d. Purchase, maintenance, repairs and accessories for approved devices.
 - e. Selection, testing and fitting of hearing aids for children with bilateral or unilateral hearing loss; and auditory training in the use of hearing aids.
 - f. Purchase and training on Department approved assistive technologies.
 - g. Balance or vestibular therapy.

iv. Cochlear Implants

1. Cochlear implants may be indicated for clients aged 12 months through 20 years under the following pre-authorization criteria:
 - a. Six months of age or older.
 - b. Limited benefit from appropriately fitted binaural hearing aids (with different definitions of "limited benefit" for children 4 years of age or younger and those older than 4 years) and a 3-6 month hearing aid trial.
 - c. Bilateral hearing loss with unaided pure tone average thresholds of 70 dB or greater.
 - d. Minimal speech perception measured using recorded standardized stimuli-speech discrimination scores of 50-60% or below with optimal amplification at 1000, 2000 and 4000 Hz.
 - e. Family support and motivation to participate in a post-cochlear aural, auditory and speech language rehabilitation program.
 - f. Assessment by an audiologist and otolaryngologist experienced in cochlear implants.
 - g. Bi lateral and hybrid/Electric Acoustic Stimulation cochlear implantation considered on a case by case basis.
 - h. No medical contraindications.
 - i. Up-to-date-immunization status as determined by the Advisory Committee on Immunization Practices (ACIP).
 - j. Replacement of an existing cochlear implant for all ages is a benefit when the currently used component is no longer functional and cannot be repaired.

v. Speech-language Services

1. Assessment – Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report:
 - a. Expressive language.
 - b. Receptive language.
 - c. Cognition.
 - d. Augmentative and alternative communication.

- e. Voice disorder.
 - f. Resonance patterns.
 - g. Articulation/phonological development.
 - h. Pragmatic language.
 - i. Fluency.
 - j. Feeding and swallowing.
 - k. Hearing status based on pass/fail criteria.
 - l. Motor speech.
 - m. Aural rehabilitation (defined by provider's scope of practice).
2. Treatment – Service may include one or more of the following, as appropriate:
- a. Articulation/phonological therapy
 - b. Language therapy including expressive, receptive, and pragmatic language.
 - c. Augmentative and alternative communication therapy. Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of Activities of Daily Living
 - d. Auditory processing/discrimination therapy
 - e. Fluency therapy.
 - f. Voice therapy.
 - g. Oral motor therapy.
 - h. Swallowing therapy.
 - i. Speech reading.
 - j. Cognitive treatment.
 - k. Necessary supplies and equipment.
 - l. Aural rehabilitation (defined by provider's scope of practice)

f. DOCUMENTATION

i. General Requirements for Client's Record of Service:

1. Rendering providers shall document all evaluations, re-evaluations, services provided, client progress, attendance records, and discharge plans. All documentation must be kept in the client's records along with a copy of the referral or prescribing provider's order.
2. Documentation shall support both the medical necessity of services and the need for the level of skill provided.
3. Rendering providers shall copy the client's prescribing provider and medical home/primary care provider on all relevant records.

ii. Documentation shall include all of the following:

1. The client's name and date of birth.
2. The date and type of service provided to the client.
3. A description of each service provided during the encounter including procedure codes and time spent on each.
4. The total duration of the encounter.
5. The name(s) and title(s) of the person(s) providing each service and the name and title of the therapist supervising or directing the services.

iii. Documentation categories

1. Provider shall keep documentation for the following episodes of care: Initial Evaluation, Re-evaluation, Visit/Encounter Notes, and Discharge Summary.
2. Written documentation of the Initial Evaluation shall include the following:
 - a. The reason for the referral and reference source.
 - b. Diagnoses pertinent to the reason for referral, including:
 - i. Date of onset;
 - ii. Any cognitive, emotional, or physical loss necessitating referral, and the date of onset, if different from the onset of the relevant diagnoses;
 - iii. Current functional limitation or disability as a result of the above loss, and the onset of the disability;

- iv. Pre-morbid functional status, including any pre-existing loss or disabilities;
 - v. Review of available test results;
 - vi. Review of previous therapies/interventions for the presenting diagnoses, and the functional changes (or lack thereof) as a result of previous therapies or interventions.
 - c. Assessment: Include a summary of the client's impairments, and functional limitations and disabilities, based on a synthesis of all findings gathered from the evaluation. Highlight pertinent factors which influence the treatment diagnosis and prognosis, and discuss the inter-relationship between the diagnoses and disabilities for which the referral was made must be discussed.
 - d. Plan of Care: A detailed Plan of Care must include the following
 - i. Specific treatment goals for the entire episode of care which are functionally-based and objectively measured.
 - e. Proposed interventions/treatments to be provided during the episode of care.
 - f. Proposed duration and frequency of each service to be provided.
 - g. Estimated duration of episode of care.
- 7. The therapist's Plan of Care must be reviewed, revised if necessary, and signed, as medically necessary by the client's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days. The Plan of Care must not cover more than a 90-day period or the time frame documented in the Individual Family Service Plan (IFSP). (27-10.5-702(7), C.R.S. (2017) states the IFSP "shall qualify as meeting the standard for medically necessary services." Therefore no physician is required to sign a work order for the IFSP.)
- 8. A Plan of Care must be certified. Certification is the physician's, physician's assistant or nurse practitioner's approval of the Plan of Care. Certification requires a dated signature on the Plan of Care or some other document that indicates approval of the Plan of Care. If the service is a Medicare covered service and is provided to a recipient who is eligible for Medicare, the Plan of Care must be reviewed at the intervals required by Medicare.

9. Re-evaluation. A re-evaluation must be done whenever there is an unanticipated change in the client's status, a failure to respond to interventions as expected or there is a need for a new Plan of Care based on new problems and goals that require significant changes to the Plan of Care. The documentation for a re-evaluation need not be as comprehensive as the initial evaluation, but must include at least the following: Reason for re-evaluation; client's health and functional status reflecting any changes; findings from any repeated or new examination elements; and, changes to Plan of Care.

iv. Visit/Encounter Notes

1. Written documentation of each encounter must be in the client's record of service. These visit notes document the implementation of the Plan of Care established by the therapist at the initial evaluation. Each visit note must include the following:
 - a. The total duration of the encounter.
 - b. The type and scope of treatment provided, including procedure codes and modifiers used.
 - c. The time spent providing each service. The number of units billed/requested must match the documentation.
 - d. Identification of the short or long term goals being addressed during the encounter.
2. In addition to the above required information, the visit note must include the following elements:
 - a. A *subjective* element which includes the reason for the visit, the client or caregiver's report of current status relative to treatment goals, and any changes in client's status since the last visit;
 - b. An *objective* element which includes the practitioner's findings, including abnormal and pertinent normal findings from any procedures or tests performed;
 - c. An *assessment* component which includes the practitioner's assessment of the client's response to interventions provided, specific progress made toward treatment goals, and any factors affecting the intervention or progression of goals; and
 - d. A *plan* component which states the plan for next visit(s).

v. Discharge Summary

1. At the conclusion of therapy services, a discharge summary must be included in the documentation of the final visit in an episode of care. This may include the following:

- a. Highlights of a client's progress or lack of progress towards treatment goals.
 - b. Summary of the outcome of services provided during the episode of care.
- g. **NON-COVERED SERVICES AND GENERAL LIMITATIONS**
 - i. Health First Colorado does not cover items and services which generally enhance the personal comfort of the eligible person but are not necessary in the diagnosis of, do not contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member.
 - ii. Maintenance programs beginning when the therapeutic goals of a treatment plan have been achieved and no further functional progress is apparent or expected to occur, are not covered for adult clients.
 - iii. Services provided without a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law are not covered, unless they are covered by an IFSP.
 - iv. Treatment of speech and language delays not associated with an acquired or chronic medical condition, neurological disorder, acute illness, injury, or congenital defect are not covered, unless they are covered by an IFSP.
 - v. Any service that is not determined by the provider to be medically necessary according to the definition of medical necessity in Section 8.076.1.8.
 - vi. Hearing aids for adults are not a covered service.
 - vii. Hearing exams and evaluations are a benefit for adults only when a concurrent medical condition exists.
 - viii. Initial placement of cochlear implants for adults **is not covered**.
 - ix. The upgrading of a cochlear implant system or component (e.g., upgrading processor from body worn to behind the ear, upgrading from single to multi-channel electrodes) of an existing properly functioning cochlear implant is not covered.
 - x. Services not documented in the client's Plan of Care are not covered.
 - xi. Services specified in a plan of care that is not reviewed and revised as medically necessary by the client's attending physician or by an IFSP are not covered.
 - xii. Services that are not designed to improve or maintain the functional status of a recipient with a physical loss or a cognitive or psychological deficit are not covered.

- xiii. A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements is not covered.
- xiv. Vocational or educational services, including functional evaluations, except as provided under IEP-related services are not covered.
- xv. Services provided by unsupervised therapy assistants as defined by the American Speech-Language Hearing Association (ASHA) are not covered.
- xvi. Treatment for dysfunction that is self-correcting (for example, natural dysfluency or developmental articulation errors) is not covered.
- xvii. Psychosocial services are not covered.
- xviii. Costs associated with record keeping documentation and travel time are not covered.
- xix. Training or consultation provided by an audiologist to an agency, facility, or other institution is not covered.
- xx. Therapy that replicates services that are provided concurrently by another type of therapy is not covered. Particularly, occupational therapy which should provide different treatment goals, plans, and therapeutic modalities from speech therapy.

8.200.4 CERTIFIED FAMILY PLANNING CLINICS

8.200.4.A Laboratories at Certified Family Planning Clinics providing services must meet all Clinical Laboratory Improvement Amendment requirements.

8.200.4.B Services at a Certified Family Planning Clinic shall be rendered under the General Supervision of a physician. General Supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

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

8.200.5 REIMBURSEMENT

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

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

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

- 8.200.5.C Dental hygienists may be directly reimbursed for unsupervised dental hygiene services.
- a. Hygienists employed by a dentist, clinic, or institution shall submit claims under the employer's provider identification number.
- 8.200.5.D The amount of reimbursement for Certified Family Planning Clinic services may be paid directly to the clinic and is the lower of the following:
1. Submitted charges; or
2. Fee schedule as determined by the Department of Health Care Policy and Financing which may be a manual pricing.
- 8.200.5.E A provider shall not be reimbursed directly for services if the provider is acting as a contract agent or employee of a nursing home, hospital, Federally Qualified Health Center, Rural Health Center, clinic, home health agency, school, or physician.
- 8.200.5.F A provider shall not be reimbursed for services as a billing provider if the provider is a student in a graduate education program and the facility where the provider delivers services receives Graduate Medical Education payments pursuant to Colorado Revised Statutes Section 25.5-4-402.5 or 10 C.C.R. 2505-10, Sections 8.300.7.

8.200.6 INCREASED MEDICAL PAYMENTS TO PRIMARY CARE PHYSICIANS PROGRAM

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

8.200.6.A Authority

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

8.200.6.B Definitions

1. Primary Care Physician means a medical doctor who attests to the Department that he or she has a primary specialty designation of family medicine, general internal medicine, or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association.
2. Personal Supervision means the physician accepts professional responsibility and legal liability for the services provided by the non-physician provider. Personal Supervision does not require physical presence at the location of the services.

8.200.6.C Attestation

1. A Primary Care Physician is required to self-identify, using the form available on the www.colorado.gov/hcpf, provider's web page, to a specialty designation of family medicine, general internal medicine or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties or the American Osteopathic Association. A physician must self-attest that he/she:
- a. Is Board certified with such a specialty or subspecialty; and/or

- b. Has furnished evaluation and management services and vaccine administration services under codes described in 8.200.6.E that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

8.200.6.D Reimbursable Services

- 1. Primary care services with procedure codes listed in 8.200.6.E provided by a Primary Care Physician, as defined in 8.200.6.B.1, are eligible for increased reimbursement.
- 2. Primary care services with procedure codes listed in 8.200.6.E provided by a Physician Assistant or Advanced Nurse Practitioner under the personal supervision of a Primary Care Physician, as defined in 8.200.6.B.1, are eligible for increased reimbursement.
 - a. For this program, when services by a non-physician provider are provided under the personal supervision of a physician, the physician may be identified as the rendering provider on claims.

8.200.6.E Procedure Codes

The procedure codes covered by the Colorado Medical Assistance program designated in the Healthcare Common Procedure Coding System (HCPCS) for increased reimbursement shall be 99201-99499 and Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474.

8.200.6.F Supplemental Payment Procedure

- 1. Supplemental payments to eligible providers are calculated in the manner defined in 42 C.F.R. part 447.405 and identified in the schedule of maximum payments published on the website of the Department of Health Care Policy and Financing. Title 42 of the Code of Federal Regulations, Part 447.405 (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or additions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203.
- 2. Supplemental payments will be made on a quarterly basis.
- 3. The initial supplemental payment will be made after approval of the State Plan Amendment approving the increase.

8.200.6.G Audits

- 1. Eligible providers shall maintain all increased payment to primary care provider program-related records including documentation to support attestations.
- 2. Eligible providers shall permit the Department, the federal government, the Medicaid Fraud Control Unit and any other duly authorized agent of a governmental agency:
 - a. To audit, inspect, examine, excerpt, copy and/or transcribe the records related to this incentive program, to assure compliance with the program requirements, Corrective Action Plans and attestations.

- b. To access the provider's premises, to inspect and monitor, at all reasonable times, the provider's compliance with program requirements, Corrective Action Plans and attestations. Monitoring includes, but is not limited to, internal evaluation procedures, examination of program data, special analyses, on-site checking, observation of employee procedures and use of electronic health information systems, formal audit examinations, or any other procedure.
 3. Eligible providers shall cooperate with the State, the federal government, the Medicaid Fraud Control Unit and any other duly authorized agent of a governmental agency seeking to audit a provider's compliance with program requirements.
 4. The Department may recoup by offset from any payment due to the provider any supplemental payment made to the provider for services rendered during the period that the provider did not meet the requirements for attestation in 8.200.6.C or does not have documentation supporting the required attestation. The Department may recoup by offset any improper or overpaid medical services paid to or on behalf of an eligible provider.
- 8.200.6.H Informal Reconsideration and Appeal
1. A provider may request an informal reconsideration of his or her exclusion from participation in the Increased Medical Payments to Primary Care Providers Program by submitting a written request within 30 days of date of notice that the provider is not eligible to participate in the program.
 2. A provider may request an informal reconsideration of the supplemental payment amount by submitting a written request within 30 days of the receipt of the supplemental payment.
 3. The Department shall respond to the request for informal reconsideration with a decision no later than 45 days after receipt of the request.
 4. A provider dissatisfied with the Department's decision may appeal the informal reconsideration decision according to the procedures set forth in 10 C.C.R. 2505-10 Section 8.050.3 PROVIDER APPEALS.

8.200.7 Prospective Medical Payments to Primary Care Medical Providers

- 8.200.7.A Definitions
1. APM code set refers to a set of Evaluation and Management (E&M) codes that are defined by the Department and included on the Department's Primary Care Alternative Payment Model Fee Schedule (<https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule>)
 2. Gainsharing refers to upside only shared savings, where a participating PCMP can earn additional reimbursement for meeting metrics/thresholds that are defined by the Department.
 3. Primary Care Medical Provider (PCMP) refers to an individual physician, advanced practice nurse or physician assistant, who participates in the Accountable Care Collaborative (ACC) as a Network Provider, with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.
 4. Prospective Payments refer to monthly payments made at the beginning of each month that are intended to cover primary care services for a PCMP's attributed members.

-
5. Qualifying Patients: The subset of medical assistance beneficiaries that are attributed to a PCMP, excluding those that are assigned to the PCMP on the basis of geographical attribution and excluding those who are eligible for Medicare. The Participating Physician's Qualifying Patients will change on an ongoing basis because of new patient attribution to the PCMP, removal of patients from the list of those attributed to the PCMP, change in attribution reason, and either gain or loss of dual Medicare and Medicaid enrollment.
 6. Reconciliation refers to a process established by the Department to correct under- or overpayment for services rendered in the APM code set.
- 8.200.7.B Eligibility for Participation
1. Primary Care Medical Providers (PCMPs) enrolled in the ACC.
 2. PCMPs must exceed a mathematical standard which is determined by the Department's actuary and this standard will be communicated to interested participants before the program starts.
 3. This payment methodology is voluntary and PCMPs must elect to participate. The Department will send a letter to confirm a PCMP's intent to join the program. The PCMP then has 10 business days from the date of receipt of the letter to confirm or deny participation.
- 8.200.7.C Prospective Per Member Per Month (PMPM) Payments
1. PCMPs will earn monthly prospective payments for services in the APM code set
 - a. The prospective PMPM payments will be PCMP specific.
 - b. The PCMP will elect what percentage of their revenue for primary care services they will earn as a prospective PMPM payment.
 - i. The amount of PMPM payment a PCMP will receive will be indicated in the letter sent by the Department to confirm participation in the program.
 - c. PCMPs will earn the rest of their revenue from reduced fee for service in the corresponding percentage for the APM code set.
 - i. The percentage reduction for the services included in the APM code set received, will be indicated in the letter sent by the Department to confirm participation in the program.
- 8.200.7.D Gainsharing
1. PCMPs will be eligible to earn extra revenue for participating in gainsharing.
 - a. Gainsharing thresholds will be specific to each PCMP.
 - b. The Department will publish thresholds for gainsharing that show the targets PCMPs must meet to be eligible to receive extra payments. Services that comprise the targets will also be published.
-

- i. PCMPs will agree to the thresholds and services for gainsharing in the letter sent by the Department which confirms participation in the program.
 - 2. The PCMP may contest the Department's determination of the gainsharing payments. PCMPs who contest the Department's determination must first submit in writing to the Department the reason for contesting the determination within 60 days of receiving the gainsharing payment. The Department will review all contested determinations within 30 calendar days of receipt of the notice and will respond to the PCMP with its final decision. If the PCMP does not agree with the Department's final decision, the PCMP has the right to file an appeal with the Office of Administrative Courts in accordance with Section 8.050.3.
- 8.200.7.E Reconciliation
- 1. A PCMP will be responsible for meeting quality minimums that are established and accepted by the PCMP in the letter sent by the Department which confirms participation in the program. The quality minimums must be met for a PCMP to earn their full prospective PMPM payments.
 - a. If the PCMP exceeds the quality minimums then they will not be subject to reconciliation, unless the PMPM payment is lower than the amount which would have been earned had the PCMP been reimbursed through the fee schedule payment
 - b. If the PCMP does not meet quality minimums then the Department will reduce the PMPM payment to equal the corresponding amount which would have been earned had the PCMP been reimbursed the fee schedule payment.
 - c. A PCMP will be made whole through an upward reconciliation process if the Department finds that a PCMP would have earned more had the PCMP been reimbursed the fee schedule payment.
 - 2. Appeals Process for Prospective PMPM Payments
 - a. The PCMP may contest the Department's determination for reconciliation of prospective PMPM payments. PCMPs who contest the Department's determination must submit in writing to the Department the reason for contesting the determination within 60 days of receiving the notice of reconciliation of prospective PMPM payments. The Department will review all contested determinations within 30 calendar days of receipt of the notice and will respond to the PCMP with its final decision. If the PCMP does not agree with the Department's final decision, the PCMP has the right to file an appeal with the Office of Administrative Courts in accordance with Section 8.050.3.
- 8.200.7.F Withdrawal from Program Participation
- 1. A PCMP may choose to voluntarily withdraw from the program at any time so long as proper notification is given to the Department.
 - a. A PCMP must give 30 days written notice to the Department to be withdrawn from the program. The PCMP will be withdrawn from the program on the first day of the month following the end of the 30 day notice period.

- b. If a PCMP chooses to voluntarily withdraw from the program before the end of the program year, the PMPM and gainsharing payments will be prorated to reflect months of participation in the program.
- 2. A PCMP may involuntarily be withdrawn from the program in the event the PCMP is terminated as a Medicaid provider and the PCMP will not be eligible to contest the determination. Involuntary withdrawal on this basis will be effective immediately. The Department will notify the PCMP in writing within 10 business days if this occurs.
- 3. The Department reserves the right to terminate the participation of a PCMP in the program at any time without cause. The Department will notify the PCMP of their termination in writing within 10 business days and the termination will become effective the first day of the month following 30 days of the notice. (Add not appealable)

8.201 ADULT DENTAL SERVICES

8.201.1 DEFINITIONS

- A. Adult Client means an individual who is 21 years or older and eligible for medical assistance benefits.
- B. Comprehensive Oral Evaluation – New or Established Patient means a thorough evaluation and documentation of a client's dental and medical history to include extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening, as defined by the Current Dental Terminology (CDT).
- C. Comprehensive Periodontal Evaluation means the procedure that is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation, as defined by the CDT.
- D. Dental Caries is a common chronic infectious transmissible disease resulting from tooth-adherent specific bacteria that metabolize sugars to produce acid which demineralizes tooth structure over time (tooth decay).
- E. Dental professional means a licensed dentist, dental hygienist, or dental therapist enrolled with Colorado Medicaid.
- F. Detailed and Extensive Oral Evaluation – Problem Focused, By Report means a detailed and extensive problem focused evaluation entailing extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation shall be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc., as defined by the CDT.
- G. Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation, as defined by the CDT.
- H. Endodontic services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues.

- I. Emergency Services means the need for immediate intervention by a physician, osteopath or dental professional to stabilize an oral cavity condition.
- J. Evaluation means a patient assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions, as defined by the CDT.
- K. High Risk of Caries is indicated in Adult Clients who present with demonstrable caries, a history of restorative treatment, dental plaque, and enamel demineralization.
- L. Immediate Intervention or Treatment is when a patient presents with symptoms and/or complaints of pain, infection or other conditions that would require immediate attention.
- M. Limited Oral Evaluation – Problem Focused means an evaluation limited to a specific oral health problem or complaint, as defined by the CDT.
- N. Oral Cavity means the jaw, mouth or any structure contiguous to the jaw.
- O. Palliative Treatment for Dental Pain means emergency treatment to relieve the client of pain; it is not a mechanism for addressing chronic pain.
- P. Periodic Oral Evaluation means an evaluation performed on a client of record to determine any changes in the patient's dental and medical status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures, as defined by the CDT.
- Q. Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal (gum) disease progression.
- R. Preventive services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries, as defined by the CDT.
- S. Prophylaxis (Cleaning) is the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.
- T. Re-Evaluation - Limited, Problem Focused (Established Patient; Not Post-Operative Visit) means assessing the status of a previously existing condition. For example, a traumatic injury where no treatment was rendered but patient needs follow-up monitoring, an evaluation for undiagnosed continuing pain, or a soft tissue lesion requiring follow-up evaluation, as defined by the CDT.
- U. Restorative means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic requirements of the client, as defined by the CDT.
- V. Year begins on the date of service.

8.201.2 BENEFITS

8.201.2.A Covered Services

- 1. Covered Evaluation Procedures:
 - a. Periodic Oral Evaluation,

- i. Shall be limited to two (2) per year.
 - ii. Is limited to any combination of two (2) periodic oral evaluations, comprehensive oral evaluations, or comprehensive periodontal oral evaluations per year.
 - iii. Must be rendered by a dental professional.
- b. Limited Oral Evaluation – Problem Focused; available to Adult Clients presenting with a specific oral health condition or problem
 - i. Shall be limited to two (2) per year per provider or location.
 - ii. Is limited to any combination of two (2) limited problem-focused oral evaluations, detailed and extensive problem-focused oral evaluations, or re-evaluation of limited and problem-focused oral evaluations per year per provider or location.
 - iii. Does not count towards other oral evaluation frequencies.
 - iv. Must be rendered by a dental professional. Dental hygienists shall only provide limited oral evaluations for an Adult Client of record.
 - v. Limited Oral Evaluation – Problem Focused will not be reimbursed if it is provided on the same day as a periodic oral evaluation, a comprehensive oral evaluation, or a comprehensive periodontal evaluation. When both are provided on the same day, only the periodic oral evaluation, the comprehensive oral evaluation, or the comprehensive periodontal evaluation will be reimbursed.
- c. Comprehensive Oral Evaluation, New or Established Patient
 - i. Shall be limited to one (1) every three (3) years per provider or location.
 - ii. Is limited to any combination of two (2) periodic oral evaluations, comprehensive oral evaluations, or comprehensive periodontal oral evaluations per year.
 - iii. Must be rendered by a dentist only.
- d. Detailed and Extensive Oral Evaluation – Problem Focused, By Report
 - i. Shall be limited to two (2) per year per provider or location.
 - ii. Is limited to any combination of two (2) limited problem-focused oral evaluations, detailed and extensive problem-focused oral evaluations, or re-evaluation of limited and problem-focused oral evaluations per year.
 - iii. Does not count towards other oral evaluation frequencies.
 - iv. Must be rendered by a dental professional.

- v. Will not be reimbursed if it is provided on the same day as a periodic oral evaluation, a comprehensive oral evaluation, or a comprehensive periodontal evaluation. When both are provided on the same day, only the periodic oral evaluation, the comprehensive oral evaluation, or the comprehensive periodontal evaluation will be reimbursed.
 - e. Re-evaluation – Limited, Problem Focused (Established Patient; Not Post-Operative Visit)
 - i. Shall be limited to two (2) per year per provider or location.
 - ii. Is limited to any combination of two (2) limited problem-focused oral evaluations, detailed and extensive problem-focused oral evaluations, or re-evaluation of limited and problem-focused oral evaluations per year.
 - iii. Does not count towards other oral evaluation frequencies.
 - iv. Must be rendered by a dental professional.
 - v. Will not be reimbursed if it is provided on the same day as a periodic oral evaluation, a comprehensive oral evaluation, or a comprehensive periodontal evaluation. When both are provided on the same day, only the periodic oral evaluation, the comprehensive oral evaluation, or the comprehensive periodontal evaluation will be reimbursed.
 - f. Comprehensive Periodontal Oral Evaluation
 - i. Shall be limited to one (1) every three (3) years.
 - ii. Is limited to any combination of two (2) periodic oral evaluations, comprehensive oral evaluations, or comprehensive periodontal oral evaluations per year.
 - iii. Must be rendered by a dental professional.
- 2. Covered Diagnostic Imaging Procedures:
 - a. Intra-oral - Complete Series of Radiographic Images, shall be limited to one (1) per five (5) years; minimum of ten (10) (periapical or posterior bitewing) images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone required in the radiographic survey counts as one (1) set of bitewings per year.
 - b. Intra-oral - Periapical First Radiographic Image, shall be limited to six (6) per one (1) year. Intra-oral first periapical x-ray will not be reimbursed if it is provided on the same day as an intra-oral - complete series. Where both are provided on the same day, only the intra-oral - complete series will be reimbursed.
 - c. Intra-oral - Periapical Each Additional Radiographic Image. Each additional periapical x-ray will not be reimbursed if it is provided on the same day as an intra-oral - complete series. Where both are provided on the same day, only the intra-oral - complete series will be reimbursed. Working and final treatment films for endodontics are not covered.

- d. Bitewing – Single Radiographic Image, shall be limited to one (1) set per year; one (1) set is equal to one (1) to four (4) films.
 - e. Bitewing – Two Radiographic Images, shall be limited to one (1) set per year; one (1) set is equal to two (2) to four (4) films.
 - f. Bitewing – Three Radiographic Images, shall be limited to one (1) set per year; one (1) set is equal to two (2) to four (4) films.
 - g. Bitewing – Four Radiographic Images, shall be limited to one (1) set per year; one (1) set is equal to two (2) to four (4) films.
 - h. Vertical Bitewings – Seven (7) to Eight (8) Radiographic Images, shall be limited to one (1) every five (5) years per provider or location. Counts as an intra-oral - complete series.
 - i. Panoramic Radiographic Image; with or without bitewing, shall be limited to one (1) per five (5) years per provider or location. Counts as an intra-oral - complete series.
3. Covered Preventive Services
- a. Prophylaxis (cleaning) shall be limited to two (2) per year. Tooth brushing alone does not qualify as a prophylaxis.
 - i. Adult Clients who indicate as high risk of periodontal disease or high risk of caries may receive any combination of up to a total of four (4) prophylaxes (cleanings) or four (4) periodontal maintenance visits per year. Indicators of high risk of periodontal disease include:
 - 1. Demonstrable caries at the time of examination;
 - 2. History of periodontal scaling and root planing;
 - 3. History of periodontal surgery;
 - 4. Diabetic diagnosis; or
 - 5. Pregnancy.
 - b. Topical Application of Fluoride Varnish, shall be limited to two (2) per year, limited to Adult Clients with:
 - i. History of dry mouth; or
 - ii. History of head or neck radiation; or
 - iii. Indication of high risk for caries as that term is defined at Section 8.201.1. If, at the end of the year the Adult Client no longer has demonstrable caries, he or she is no longer considered high risk.

Limited to any combination of two (2) topical application of fluoride varnish or topical application of fluoride per year.

- c. Topical Application of Fluoride, shall be limited to two (2) per year, limited to Adult Clients with:
 - i. History of dry mouth; or
 - ii. History of head or neck radiation; or
 - iii. Indication of high risk for caries as that term is defined at Section 8.201.1. If, at the end of the year the Adult Client no longer has demonstrable caries, he or she is no longer considered high risk.
 - iv. Limited to any combination of two (2) fluoride varnish or topical fluoride applications per year.
- 4. Covered Minor Restorative Services.
 - a. Routine amalgam and composite fillings on posterior and anterior teeth are covered services.
 - b. Amalgam and composite fillings shall be limited to one (1) time per surface per tooth, every three (3) years. The limitation shall begin on the date of service and multi-surface fillings are allowable. Amalgam and composite fillings will not be reimbursed if it is provided on the same day of treatment as a crown on the same tooth. Where both are provided on the same day, only the crown will be reimbursed.
 - c. The occlusal surface is exempt from the three (3) year frequency limitations listed under Section 8.201.2.A.4.b. when a multi-surface restoration is required or following endodontic therapy.
 - d. Prefabricated Stainless Steel Crown, Permanent Tooth; may be replaced once every three (3) years.
 - e. Prefabricated Stainless Steel Crown, with Resin Window; may be replaced once every three (3) years.
 - f. Protective Restoration, shall be limited to once per lifetime per tooth, primary and permanent teeth.
- 5. Covered Major Restorative Services
 - a. The following crowns are covered:
 - i. Single crowns, shall be limited to one (1) per tooth every seven (7) years.
 - ii. Core build-up, building shall be limited to one (1) per tooth every seven (7) years.
 - iii. Pre-fabricated post and core, shall be limited to one (1) per tooth every seven (7) years.
 - b. Crowns are covered services only when all of the following conditions are met:
 - i. The tooth is in occlusion; and

- ii. The cause of the problem is either decay or fracture; and
 - iii. The tooth is not a third molar; and
 - iv. The tooth is not a second molar, unless crowning the second molar is necessary to support a partial denture or to maintain eight (8) artificial or natural posterior teeth in occlusion; and
 - v. The Adult Client's record reflects evidence of good and consistent oral hygiene; and One of the following is also true:
 - 1. The tooth in question requires a multi-surface restoration and it cannot be restored with other restorative materials; or
 - 2. A crown is requested by the dental professional for cracked tooth syndrome and the tooth is symptomatic and appropriate testing and documentation is provided.
 - c. Crown materials are limited to porcelain, full porcelain, noble metal, or high noble metal on anterior teeth and premolars.
- 6. Covered Endodontic Services
 - a. The following endodontic procedures are covered:
 - i. Pulpal debridement shall be limited to one (1) per tooth per lifetime, permanent teeth only.
 - 1. Covered in emergency situations only.
 - 2. Exempt from prior authorization process but may be subject to post-treatment and pre-payment review.
 - 3. Will not be reimbursed when root canal is completed on the same day by the same dental provider or location.
 - ii. Root Canal, Anterior Tooth shall be limited to one (1) per tooth per lifetime, permanent teeth only.
 - iii. Root Canal, Bicuspid Tooth shall be limited to one (1) per tooth per lifetime, permanent teeth only.
 - iv. Root canal, Molar Tooth shall be limited to one (1) per tooth per lifetime, permanent teeth only.
 - v. Retreatment of Previous Root Canal Therapy, Anterior Tooth shall be limited to one (1) per lifetime; permanent teeth only. Will not be reimbursed if the original treatment was previously reimbursed to the same dental provider or location by Colorado Medicaid. Requires prior authorization.

- vi. Retreatment of Previous Root Canal Therapy, Bicuspid Tooth shall be limited to one (1) per lifetime; permanent teeth only. Will not be reimbursed if the original treatment was previously reimbursed to the same dental provider or location by Colorado Medicaid. Requires prior authorization.
 - vii. Retreatment of Previous Root Canal Therapy, Molar Tooth shall be limited to one (1) per lifetime; permanent teeth only. Will not be reimbursed if the original treatment was previously reimbursed to the same dental provider or location by Colorado Medicaid. Requires prior authorization.
 - b. Endodontic procedures are covered services when:
 - i. The tooth is not a third molar; and
 - ii. The tooth is not a second molar; root canal treatment on second molars is covered only when the second molar is necessary to support a partial denture or to maintain eight (8) artificial or natural posterior teeth in occlusion; and
 - iii. The Adult Client's record reflects evidence of good and consistent oral hygiene; and
 - 1. The cause of the problem is either decay or fracture; and one of the following is also true:
 - a. The tooth is in occlusion; or
 - b. A root canal is requested by the dental professional for cracked tooth syndrome and the tooth is symptomatic and appropriate testing and documentation is provided.
 - c. In all instances in which the Adult Client is in acute pain or there exist acute trauma, the dentist should take the necessary steps to relieve the pain and complete the Emergency Services. In these instances, there may not be time for prior authorization. Such emergency services shall be subject to post-treatment and pre-payment review.
 - d. Working films (including the final treatment film) for endodontic procedures are considered part of the procedure and will not be paid for separately.
7. Covered Periodontal Treatment
- a. Gingivectomy or Gingivoplasty, Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant shall be limited to one (1) per three (3) years per Adult Client per quadrant. Includes six (6) months of postoperative care.
 - b. Gingivectomy or gingivoplasty, One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant shall be limited to one (1) per three (3) years per Adult Client per quadrant. Includes six (6) months of postoperative care.
 - c. Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth shall be limited to one (1) per three (3) years per Adult Client per quadrant.

- d. Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis; shall be limited to one (1) per three (3) years per Adult Client.
 - i. Full mouth debridement will not be reimbursed if Adult Client's patient record demonstrates that the Adult Client has had a prophylaxis (cleaning) or periodontal maintenance in the previous twelve (12) month period.
 - ii. Other periodontal treatments will not be reimbursed when provided on the same date as full mouth debridement. Where other periodontal services are provided on the same day, only the full mouth debridement will be reimbursed.
 - iii. Prophylaxis (cleaning) will not be reimbursed if it is provided on the same day as full mouth debridement. Where both are provided on the same day, only the full mouth debridement will be reimbursed.
- e. Periodontal Scaling and Root Planing, Four (4) or More Teeth per Quadrant shall be limited to one (1) per quadrant every three (3) years. Requires prior authorization.
 - i. Only covered by report. Periodontal disease must be documented in the patient record.
 - ii. Prophylaxis (cleaning) will not be reimbursed if it is provided on the same day as a periodontal scaling and root planing, four (4) or more teeth per quadrant. Where both are provided on the same day, only the periodontal scaling and root planing, four (4) or more teeth per quadrant will be reimbursed.
 - iii. No more than two (2) quadrants per day.
- f. Periodontal Scaling and Root Planing, One (1) to Three (3) Teeth per Quadrant shall be limited to one (1) per quadrant every three (3) years. Requires prior authorization.
 - i. Only covered by report. Periodontal disease must be documented in the patient record.
 - ii. Prophylaxis (cleaning) will not be reimbursed if it is provided on the same day as a periodontal scaling and root planing, one (1) to three (3) teeth per quadrant. Where both are provided on the same day, only the periodontal scaling and root planing, one (1) to three (3) teeth per quadrant will be reimbursed.
 - iii. No more than two (2) quadrants per day.
- g. Periodontal Maintenance, shall be limited to two (2) times per year; counts as a prophylaxis (cleaning).
 - i. Adult Clients who indicate as high risk of periodontal disease or high risk of caries may receive any combination of up to a total of four (4) prophylaxes (cleanings) or four (4) periodontal maintenance visits per year. Indicators of high risk of periodontal disease include:

1. Demonstrable caries at the time of examination;
 2. History of periodontal scaling and root planing;
 3. History of periodontal surgery;
 4. Diabetic diagnosis; or
 5. Pregnancy.
- h. In all instances in which the Adult Client is in acute pain or there exist acute trauma, the dentist should take the necessary steps to relieve the pain and complete the Emergency Services. In these instances, there may not be time for prior authorization. Such emergency services shall be subject to post-treatment and pre-payment review.
8. Covered Removable Prosthetics
 - a. Removable prosthetics are not covered if eight (8) or more posterior teeth (natural or artificial) are in occlusion. Anterior teeth shall be covered, irrespective of the number of teeth in occlusion.
 - b. Removable prosthetics covered include:
 - i. Complete Upper Dentures shall be limited to one (1) time every seven (7) years. Includes initial six (6) months of relines. Requires prior authorization.
 - ii. Complete Lower Dentures shall be limited to one (1) time every seven (7) years. Includes initial six (6) months of relines. Requires prior authorization.
 - iii. Removable Partial Upper Denture, Resin Based shall be limited to one (1) time every seven (7) years. Requires prior authorization.
 - iv. Removable Partial Lower Denture, Resin Based shall be limited to one (1) time every seven (7) years. Requires prior authorization.
 - v. Removable Partial Upper Denture, Cast Metal Framework shall be limited to one (1) time every seven (7) years. Requires prior authorization.
 - vi. Removable Partial Lower Denture, Cast Metal Framework shall be limited to one (1) time every seven (7) years. Requires prior authorization.
 - vii. Removable Partial Upper Denture, Flexible Base shall be limited to one (1) time every seven (7) years. Requires prior authorization.
 - viii. Removable Partial Lower Denture, Flexible Base shall be limited to one (1) time every seven (7) years. Requires prior authorization.
9. Covered Oral Surgery, Palliative Treatment and Anesthesia
 - a. The following surgical and palliative treatments are covered:

-
- i. Simple Extraction shall be limited to one (1) time per tooth.
 - ii. Surgical Extraction shall be limited to one (1) time per tooth.
 - iii. Incision and Drainage of Abscess, concurrent with extraction will be covered by report when narrative of medical necessity can be documented. Will not be reimbursed in same surgical area and on same visit as any other definitive treatment codes, except for covered services necessary for diagnosis. Such incision and drainage procedures may be subject to post-treatment and pre-payment review.
 - iv. Minor surgical procedures to prepare the mouth for removable prostheses shall be limited to one (1) time per lifetime per quadrant.
 - v. Palliative Treatment of Dental Pain will not be reimbursed on same visit as any definitive treatment codes; except for radiographs necessary for diagnosis. Will not be reimbursed when only other service is writing a prescription.
 - vi. Deep Sedation/General Anesthesia.
 - 1. Only covered for Adult Clients when there is sufficient evidence to support medical necessity.
 - 2. Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed.
 - vii. Intravenous Conscious Sedation.
 - 1. Only covered for Adult Clients when there is sufficient evidence to support medical necessity.
 - 2. Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed.
 - b. In all instances in which the Adult Client is in acute pain or there exist acute trauma, the dentist should take the necessary steps to relieve the pain and complete the Emergency Services. In these instances, there may not be time for prior authorization. Such emergency services shall be subject to post-treatment and pre-payment review.
 - c. Biopsies are covered only in instances where there is a suspicious lesion.
 - d. Removal of third molars is only covered in instances of acute pain and overt symptomatology.
10. Covered Hospital-Based Services
- a. Dental treatment is covered in a hospital or outpatient facility, under deep sedation or general anesthesia, only when there is medical necessity.
 - b. Under this Section 10, medical necessity shall be limited to the following:
-

- i. Patients with a documented physical, mental or medically compromising condition.
- ii. Patients who have a dental need and for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
- iii. Patients who are extremely uncooperative, unmanageable, anxious or uncommunicative and who have dental needs deemed sufficiently urgent that care cannot be deferred. Evidence of the attempt to manage in an outpatient setting must be provided; or
- iv. Patients who have sustained extensive orofacial and dental trauma.
- c. All operating room cases require prior authorization, even if the complete treatment plan is not available.
- d. General anesthesia and sedation are not covered services when the patient is cooperative and requires minimal dental treatment, or when the patient has a concomitant medical condition which would make general anesthesia or sedation unsafe.

8.201.2.B. Exclusions.

- 1. The following services/treatments are not a benefit for Adult Clients age 21 years and older under any circumstances:
 - a. Cosmetic Procedures.
 - b. Crowns in the following categories:
 - i. Cosmetic Crowns (i.e., crowns solely for cosmetic purposes);
 - ii. Multiple units of crown and bridge;
 - iii. To restore vertical dimension;
 - iv. When an Adult Client has active and advanced periodontal disease;
 - v. When the tooth is not in occlusion; or
 - vi. When there is evidence of periapical pathology.
 - c. Implants.
 - d. Screening and assessment.
 - e. Periodontal surgery.
 - f. Graft procedures.
 - g. Endodontic surgery.
 - h. Treatment for temporomandibular joint disorders.
 - i. Orthodontic treatment.

- j. Tobacco cessation counseling.
- k. Oral hygiene instruction.
- l. Any service that is not listed as covered.

8.201.3 PRIOR AUTHORIZATION REQUEST

1. Emergency Services do not require a prior authorization before services can be rendered, and shall be subject to pre-payment review.
2. Prior authorizations or benefits shall be denied for reasons of poor dental prognosis, lack of dental necessity or appropriateness or because the requested services do not meet the generally accepted standard of dental care.
3. The following services require prior authorization:
 - a. Complete and partial dentures.
 - b. Scaling and root planing (periodontal maintenance).
 - c. Retreatment of root canals.
 - d. Hospital-based services when treatment is required.
 - e. Unspecified procedures, by report.

8.201.4. PROVIDER REQUIREMENTS/REIMBURSEMENT

8.201.4.A. Dental services shall only be provided by a licensed dental professional who is enrolled with Colorado Medicaid. Providers shall only provide covered services that are within the scope of their practice.

8.201.4.B. The following billing limitations apply:

1. Restorations:
 - a. Tooth preparation, anesthesia, all adhesives, liners and bases, polishing and occlusal adjustments shall be included within the reimbursement rate for restoration. Unbundling of dental restorations for billing purposes is not allowed.
 - b. Amalgam and composite restorations shall be reimbursed at the same rate.
 - c. Claim payment to a dental provider for one (1) or more restorations for the same tooth shall be limited to a total of four (4) or more tooth surfaces.

8.201.5 ELIGIBLE CLIENTS

Dental services described in 8.201.2 shall apply to Adult Clients age 21 years and older.

8.201.6 ANNUAL LIMITS

1. Beginning July 1, 2019, dental services for Adult Clients age 21 years and older shall be limited to a total of \$1,500 per Medicaid Adult Client per state fiscal year. An Adult Client may make personal expenditures for any dental services that exceed the \$1,500 annual limit.

2. The complete and partial dentures benefit shall be subject to prior authorization and shall not be subject to the annual maximum for dental services for Adult Clients age 21 years and older. Although the complete and partial dentures benefit is not subject to the annual maximum for the adult dental services, it shall be subject to a set Medicaid allowable rate.

8.202 DENTAL SERVICES FOR CHILDREN

8.202.1 DEFINITIONS

Apexication is a method of inducing a calcified barrier at the apex of a nonvital tooth with incomplete root formation.

Apexogenesis refers to a vital pulp therapy procedure performed to encourage physiological development and formation of the root end.

Child Client means an individual who is age 20 years or under and eligible for medical assistance benefits.

Comprehensive Oral Evaluation means a thorough evaluation and documentation of a client's dental and medical history to include extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening, as defined by the Current Dental Terminology (CDT) (2014).

Comprehensive Periodontal Evaluation means the procedure that is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation, as defined by the Current Dental Terminology (CDT) (2014).

Dental Caries is a common chronic infectious transmissible disease resulting from tooth-adherent specific bacteria that metabolize sugars to produce acid which demineralizes tooth structure over time (tooth decay).

Dental professional means licensed dentist or dental hygienist enrolled with Colorado Medicaid.

Detailed and Extensive Oral Evaluation – Problem Focused, By Report means a detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc., as defined by the Current Dental Terminology (CDT) (2014).

Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation, as defined by the Current Dental Terminology (CDT) (2014).

Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Services means services that are available to clients 20 and under which are determined to be medically necessary and offered through the State Plan even if not available to other eligibility categories.

Endodontic services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues.

Emergency Services means the need for immediate intervention by a physician, osteopath or dental professional to stabilize an oral cavity condition.

Evaluation means a patient assessment that includes gathering of information through interview, observation, examination, and use of specific tests to diagnose existing conditions, as defined by the Current Dental Terminology (CDT) (2014).

High Risk of Caries is indicated in Child Clients who present with demonstrable caries, a history of restorative treatment, dental plaque, and enamel demineralization; or Child Clients of mothers with a high caries rate, especially with untreated caries; or Child Clients who sleep with a bottle containing anything other than water, or who breastfeed throughout the night (at-will nursing); or Child Clients with special health care needs.

Immediate Intervention or Treatment is when a patient presents with symptoms and/or complaints of pain, infection or other conditions that would require immediate attention.

Limited Oral Evaluation – Problem Focused means an evaluation limited to a specific oral health problem or complaint, as defined by the Current Dental Terminology (CDT) (2014).

Oral Cavity means the jaw, mouth or any structure contiguous to the jaw.

Oral Evaluation For A Patient Under Three Years of Age And Counseling With Primary Caregiver means the diagnostic services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver, as defined by the Current Dental Terminology (CDT) (2014).

Palliative Treatment for Dental Pain means emergency treatment to relieve the client of pain; not a mechanism for addressing chronic pain.

Periodic Oral Evaluation means an evaluation performed on a client of record to determine any changes in the patient's dental and medical status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures, as defined by the Current Dental Terminology (CDT) (2014).

Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal (gum) disease progression.

Preventive services means services concerned with promoting good oral health and function by preventing or reducing the onset or development of oral diseases or deformities and the occurrence of oro-facial injuries, as defined by the Current Dental Terminology (CDT) (2014).

Prophylaxis (Cleaning) is the removal of dental plaque and calculus from teeth in order to prevent dental caries, gingivitis and periodontitis.

Qualified Medical Personnel means physicians (MDs), osteopaths (DOs), nurse practitioners and physician assistants with a focus on primary care, general practice, internal medicine, pediatrics and who have participated in on-site training by the "Cavity Free at Three" team or have completed Module 2 (child oral health) and Module 6 (fluoride varnish) in the Smiles for Life curriculum when treating Child Clients age 0 years through 12 years of age. The qualified medical personnel must have participated in Module 3 (adult oral health) and Module 6 (fluoride varnish) in the Smiles for Life curriculum when treating Child Clients ages 12 years and older. Qualified medical personnel who complete this training must provide the documentation of this training when requested.

Re-Evaluation - Limited, Problem Focused (Established Patient; Not Post-Operative Visit) means assessing the status of a previously existing condition. For example, a traumatic injury where no treatment was rendered but patient needs follow-up monitoring; an evaluation for undiagnosed continuing pain; or a soft tissue lesion requiring follow-up evaluation, as defined by the Current Dental Terminology (CDT) (2014).

Restorative means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic requirements of the client, as defined by the Current Dental Terminology (CDT) (2014).

Screening means a program designed to evaluate the health status and potential of an individual. In the process it may be found that a person has a particular disease or condition or is at greater-than-normal risk of its development. Screening may include taking a personal and family health history and performing a physical examination, tests, laboratory tests, or radiologic examination and may be followed by counseling, education, referral, or further testing.

Special Healthcare Needs means any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs. The condition may be developmental or acquired and may cause limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Year begins on the date of service.

8.202.2 BENEFITS

8.202.2.A Covered Services

1. Covered Evaluation Procedures:

- a. Oral Evaluation For A Patient Under Three Years of Age And Counseling With Primary Caregiver; shall be limited to Child Clients age 0 through 2, two (2) per year per provider or location.
 - i. Oral Evaluation For A Patient Under Three Years of Age And Counseling With Primary Caregiver shall include:
 1. Risk assessment;
 2. Oral hygiene instruction; and
 3. Anticipatory guidance.
 - ii. For Child Clients age 0 through 2 who are at high risk for caries, an additional two (2) Oral Evaluation For A Patient Under Three Years of Age And Counseling With Primary Caregiver is allowed per year for a total of four (4) per year; a formal caries risk assessment shall be performed and documented as part of the patient record.
 - iii. May be performed by dental professional or qualified medical personnel.
 - iv. Oral Evaluation For A Patient Under Three Years of Age And Counseling With Primary Caregiver will not be reimbursed if it is provided on the same day as a periodic oral evaluation. When both are provided on the same day, only the periodic oral evaluation will be reimbursed.

- b. Screening for Child Clients ages 3 and 4, Including State or Federally Mandated Screenings; shall be limited to two (2) per year.
 - i. For Child Clients ages 3 and 4 who are at high risk for caries, an additional two (2) screenings is allowed per year for a total of four (4) per year; a formal caries risk assessment must be performed and documented as part of the patient record.
 - ii. Shall be performed by a dental professional or qualified medical personnel.
 - iii. A screening will not be reimbursed if it is provided on the same day of service as any comprehensive, periodic, periodontal, oral evaluation for patient under three years of age and counseling with primary caregiver, or limited oral problem focused evaluation. When provided on the same day, only the comprehensive, periodic, periodontal, oral evaluation for patient under three years of age and counseling with primary caregiver, or limited oral problem focused evaluation will be reimbursed.
- c. Screening of a Patient; shall be limited to Child Clients ages 5 years and older, three (3) per year.
 - i. Shall be performed by dental professional or qualified medical personnel.
 - ii. Does not count towards other evaluation frequency limits.
 - iii. A screening will not be reimbursed if it is provided on the same day of service as any comprehensive, periodic, periodontal, oral evaluation for patient under three years of age and counseling with primary caregiver, or limited oral problem focused evaluation. When provided on the same day, only the comprehensive, periodic, periodontal, oral evaluation for patient under three years of age and counseling with primary caregiver, or limited oral problem focused evaluation will be reimbursed.
- d. Periodic Oral Evaluation, Established Patient; shall be limited to two (2) per year per provider or location.
 - i. Limited to any combination of two (2) comprehensive, periodic, periodontal, oral evaluation for patient under three years of age and counseling with primary caregiver, or limited oral problem focused evaluations per year.
 - ii. Must be rendered by a dental professional.
 - iii. Periodic oral evaluation will not be reimbursed if it is provided on the same day as an oral evaluation for a patient under three years of age and counseling with primary caregiver. When both are provided on the same day, only the periodic oral evaluation will be reimbursed.
- e. Limited Oral Evaluation – Problem Focused; available to Child Clients presenting with a specific oral health condition or problem shall be limited to limited to two (2) per year per provider or location.
 - i. Must be rendered by a dental professional. Dental hygienists shall only provide limited oral evaluations for a Child Client of record.

- ii. Does not count against other oral exam frequencies.
 - f. Comprehensive Oral Evaluation, New or Established Patient; shall be limited to one (1) every three (3) years per provider or location.
 - i. Limited to any combination of two (2) comprehensive, periodic, periodontal, oral evaluation for patient under three years of age and counseling with primary caregiver, or limited oral problem focused evaluations per year.
 - ii. Must be rendered by a dental professional.
 - g. Detailed and Extensive Oral Evaluation – Problem Focused, By Report; shall be limited to two (2) per year per provider or location.
 - i. Limited to any combination of two (2) comprehensive, periodic, periodontal, oral evaluation for patient under three years of age and counseling with primary caregiver, or limited oral problem focused evaluations per year.
 - ii. Must be rendered by a dental professional.
 - h. Re-evaluation – Limited, Problem Focused (Established Patient; Not Post-Operative Visit); shall be limited to two (2) per year per provider or location.
 - i. Limited to any combination of two (2) comprehensive, periodic, periodontal, oral evaluation for patient under three years of age and counseling with primary caregiver, or limited oral problem focused evaluations per year.
 - ii. Must be rendered by a dental professional.
 - i. Comprehensive Periodontal Oral Evaluation, New or Established Patient; shall be limited to Child Clients ages 15 through 20, one (1) per year per provider or location.
 - i. Limited to any combination of two (2) comprehensive, periodic, periodontal, oral evaluation for patient under three years of age and counseling with primary caregiver, or limited oral problem focused evaluations per year.
 - ii. Must be rendered by a dental professional.
- 2. Covered Diagnostic Imaging Procedures:
 - a. Intra-oral; complete series, for Child Clients age 6 through 20, shall be limited to one (1) per five (5) years per provider or location; minimum of ten (10) (periapical or posterior bitewing) images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone required in the radiographic survey counts as one (1) set of bitewings per year.
 - b. Intra-oral first periapical x-ray, shall be limited to six (6) per one (1) year per provider or location. Intra-oral first periapical x-ray will not be reimbursed if it is provided on the same day as a full mouth series. Where both are provided on the same day, only the full mouth series will be reimbursed.

- c. Each additional periapical x-ray. Each additional periapical x-ray will not be reimbursed if it is provided on the same day as a full mouth series. Where both are provided on the same day, only the full mouth series will be reimbursed. Working and final treatment films for endodontics are not covered.
 - d. Bitewing; single image, shall be limited to Child Clients ages 2 through 20, one (1) set per year per provider or location; one set is equal to one (1) to four (4) films.
 - i. For Child Clients ages 2 through 20 years who are at high risk of caries, bitewing x-rays are a benefit once every six (6) months.
 - e. Bitewing; two images, shall be limited to Child Clients ages 2 through 20, one (1) set per year per provider or location; one (1) set is equal to two (2) to four (4) films.
 - i. For Child Clients ages 2 through 20 who are at high risk of caries, bitewing x-rays are a benefit once every six (6) months.
 - f. Bitewing; three images, shall be limited to Child Clients ages 10 through 20, one (1) set per year per provider or location; one (1) set is equal to two (2) to four (4) films.
 - i. For Child Clients ages 10 through 20 who are at high risk of caries, bitewing x-rays are a benefit once every six (6) months.
 - g. Bitewing; four images, shall be limited to Child Clients ages 10 through 20, one (1) set per year per provider or location; one (1) set is equal to two (2) to four (4) films.
 - i. For Child Clients ages 10 through 20 who are at high risk of caries, bitewing x-rays are a benefit once every six (6) months.
 - h. Vertical bitewings; shall be limited to Child Clients ages 6 through 20, seven (7) to eight (8) images, one (1) every five (5) years per provider or location. Counts as a full mouth series.
 - i. Panoramic image; shall be limited to Child Clients ages 6 through 20, with or without bitewing, one (1) per three (3) years per provider or location. Counts as full mouth series.
 - i. For Child Clients age 6 or under with trauma or suspected pathology, additional panoramic films may be approved subject to EPSDT guidelines.
 - j. Occlusal film; shall be limited to one (1) per arch per two (2) years per provider or location.
 - i. For Child Clients with trauma or pulpal treatment, additional occlusal films may be approved subject to EPSDT guidelines.
3. Covered Preventive Services
- a. Dental Prophylaxis (Cleaning); shall be limited to two (2) per year. Tooth brushing alone does not qualify as a prophylaxis.

- b. Fluoride varnish or fluoride gel, shall be limited to two (2) per year. Fluoride rinse is not a covered benefit.
 - i. Ages 0 through 4:
 - 1. Child Clients at high risk of caries may receive an additional two (2) per year for a total of four (4) per year; a formal caries risk assessment must be performed and documented as part of the Clients medical record.
 - 2. May be provided by dental professional or qualified medical personnel.
 - a. Qualified medical personnel administering this service must do so:
 - i. in conjunction with an oral evaluation for a patient under age 3 (up until day before the third birthday); or
 - ii. in conjunction with a screening for patients ages 3 through 4 (up until day before the fifth birthday).
 - 3. Fluoride varnish is the only acceptable topical treatment for Child Clients age 0 through 4.
 - 4. Only qualified medical personnel and dental professionals may perform this service.
 - ii. Age 5 and older:
 - 1. Child Clients age 5 and over may receive an additional one (1) per year with no adjustment for risk for a total of three (3) per year.
 - 2. Fluoride varnish is the only acceptable topical treatment for Child Clients age 5. Fluoride gel will be reimbursed for Child Clients ages 6 and over.
 - 3. Only qualified medical personnel and dental professionals shall perform this service.
- c. Sealants for Child Clients ages 5 through 15, shall be limited to two (2) per lifetime per tooth. Sealants are limited to:
 - i. Permanent molars only.
 - ii. Occlusal surfaces only.
 - iii. Tooth must be caries-free and have no restorations.

- d. Child Clients age 20 or under who indicate as high risk of periodontal disease or high risk of caries may receive any combination of up to four (4) prophylaxes (cleanings) or four (4) periodontal maintenance visits per year. Indicators of high risk of periodontal disease include:
 - i. Active and untreated caries (decay) at the time of examination; or
 - ii. History of periodontal scaling and root planning; or
 - iii. History of periodontal surgery; or
 - iv. Diabetic diagnosis; or
 - v. Pregnancy.
- 4. Covered Space Maintenance.
 - a. Fixed Space Maintainers for Lost Primary Molars; shall be limited to Child Clients age 0 through 14, two (2) per quadrant per lifetime. Includes maintenance and repair.
 - b. Removable Space Maintainers for Lost Primary Molars; shall be limited to Child Clients age 0 through 14, two (2) per quadrant per lifetime. Includes maintenances and repair.
 - c. Re-cementation of Space Maintainer; shall be limited to Child Clients age 0 through 14, one (1) per year. Will not be reimbursed within six (6) months of original placement by the same dentist or group.
 - d. Removal of a Fixed Space Maintainer; shall be limited to Child Clients age 0 through 20, one (1) per lifetime. Will not be reimbursed to the dentist who placed the appliance or the group where the appliance was originally delivered within six (6) months of original placement. May be subject to post-treatment and pre-payment review.
- 5. Covered Minor Restorative Services.
 - a. Routine amalgam and composite fillings on posterior and anterior teeth are covered services. Restoration of primary teeth close to exfoliation is not covered.
 - i. For Child Clients who present with overt symptomatology or ectopic eruption because of an inability to extract the exfoliating teeth themselves, extraction of primary teeth may be approved subject to EPSDT guidelines.
 - b. The occlusal surface is exempt from the three (3) year frequency limitations listed below when a multi-surface restoration is required or following endodontic therapy.
 - c. Amalgam and composite fillings shall be limited to one (1) time per surface per tooth, every three (3) years. The limitation shall begin on the date of service and multi-surface fillings are allowable. Amalgam and composite fillings will not be reimbursed if it is provided on the same day of treatment as a crown. Where both are provided on the same day, only the crown will be reimbursed.

- d. Prefabricated Stainless Steel Crown, Primary Tooth; may be replaced once every three (3) years.
 - e. Prefabricated Stainless Steel Crown, Permanent Tooth; may be replaced once every three (3) years.
 - f. Prefabricated Stainless Steel Crown, with Resin Window; may be replaced once every three (3) years.
 - g. Protective Restoration, shall be limited to once per lifetime per tooth, primary and permanent teeth.
 - h. Interim Therapeutic Restoration, Primary Dentition; shall be limited to once per lifetime per tooth, primary teeth only. Not considered a definitive restoration.
6. Covered Major Restorative Services
- a. The following crowns are a covered service:
 - i. Single crowns, shall be limited to one (1) per tooth every seven (7) years. Requires prior authorization.
 - ii. Core build-up; building, shall be limited to one (1) per tooth every seven (7) years. Requires prior authorization.
 - iii. Pre-fabricated post and core, shall be limited to one (1) per tooth every seven (7) years. Requires prior authorization.
 - b. Permanent crowns shall be limited to Child Clients ages 16 years and older.
 - c. Crowns are covered services only when all of the following conditions are met:
 - i. The tooth is in occlusion; and
 - ii. The cause of the problem is either decay or fracture; and
 - iii. The tooth is not a third molar; and
 - iv. The Child Client's record reflects evidence of good and consistent oral hygiene; and one of the following is also true:
 - 1. The tooth in question requires a multi-surface restoration and it cannot be restored with other restorative materials; or
 - 2. A crown is requested by the dental professional through the prior authorization process for cracked tooth syndrome and the tooth is symptomatic and appropriate testing and documentation is provided.
 - d. Crown materials shall be limited to porcelain, full porcelain, noble metal, or high noble metal, on anterior teeth and premolars.

7. Covered Endodontic Services

a. The following endodontic procedures are covered:

- i. Therapeutic Pulpotomy (Excluding Final Restoration; removal of the top part of the pulp and application of medicament), shall be limited to one (1) per tooth per lifetime, primary teeth only. Therapeutic Pulpotomy is not allowable as the first state of root canal treatment or for Apexogenesis. Will not be reimbursed if the original treatment was previously reimbursed to the same Provider by Colorado Medicaid.
- ii. Pulpal Debridement, shall be limited to one (1) per tooth per lifetime; permanent teeth only.
 1. Covered in emergency situations only.
 2. Exempt from prior authorization process but may be subject to post-treatment and pre-payment review.
 3. Will not be reimbursed when root canal is completed on the same day by the same dentist or dental office.
- iii. Partial Pulpotomy for Apexogenesis; shall be limited to one (1) per tooth per lifetime; permanent teeth only.
 1. Exempt from prior authorization process but may be subject to post-treatment and pre-payment review.
- iv. Root Canal, Anterior Tooth; shall be limited to one (1) per tooth per lifetime; permanent teeth only.
- v. Root Canal, Bicuspid; shall be limited to one (1) per tooth per lifetime; permanent teeth only.
- vi. Root Canal, Molar; shall be limited to one (1) per tooth per lifetime; permanent teeth only.
- vii. Retreatment of Previous Root Canal Therapy, Anterior Tooth; shall be limited to one (1) per lifetime; permanent teeth only. Will not be reimbursed if the original treatment was previously reimbursed to the same dentist or group by Colorado Medicaid. Requires prior authorization.
- viii. Retreatment of Previous Root Canal Therapy, Bicuspid Tooth; shall be limited to one (1) per tooth per lifetime. Will not be reimbursed if the original treatment was previously reimbursed to the same dentist or group by Colorado Medicaid. Requires prior authorization.
- ix. Retreatment of Previous Root Canal Therapy, Posterior Tooth; shall be limited to one (1) per tooth per lifetime. Will not be reimbursed if the original treatment was previously reimbursed to the same dentist or group by Colorado Medicaid. Requires prior authorization.
- x. Apexification/ Recalcification procedures; shall be limited to one (1) per tooth per lifetime; permanent teeth only.

-
1. Exempt from prior authorization process but may be subject to post-treatment and pre-payment review.
 - xi. Pulpal Regeneration; shall be limited to one (1) per tooth per lifetime.
 1. Exempt from prior authorization process but may be subject to post-treatment and pre-payment review.
 - b. Endodontic procedures are covered services when:
 - i. The tooth is not a third molar; and
 - ii. The Child Client's record reflects evidence of good and consistent oral hygiene; and
 1. The cause of the problem is either decay or fracture; and one of the following is also true:
 - a. The tooth is in occlusion; or
 - b. A root canal is requested by the dental professional through the prior authorization process for cracked tooth syndrome and the tooth is symptomatic and appropriate testing and documentation is provided.
 - c. In all instances in which the Child Client is in acute pain or there exists acute trauma, the dentist should take the necessary steps to relieve the pain and complete the Emergency Services. In these instances, there may not be time for prior authorization. Such emergency services shall be subject to post-treatment and pre-payment review.
 - d. Working films (including the final treatment film) for endodontic procedures are considered part of the procedure and will not be reimbursed separately.
8. Covered Periodontal Treatment
 - a. Gingivectomy or Gingivoplasty, Four or More Contiguous Teeth or Tooth Bounded Spaces per Quadrant; shall be limited to one (1) per three (3) years per Child Client per quadrant. Includes six (6) months of postoperative care. Requires prior authorization.
 - b. Gingivectomy or gingivoplasty, One to Three Contiguous Teeth or Tooth Bounded Spaces per Quadrant; shall be limited to one (1) per three (3) years per Child Client per quadrant. Includes six (6) months of postoperative care. Requires prior authorization.
 - c. Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per Tooth; shall be limited to one (1) per three (3) years per Child Client per quadrant.
 - d. Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis; shall be limited to Child Clients ages 13 through 20.
-

- i. Exempt from prior authorization process for Child Clients ages 13 through 20 but may be subject to post-treatment and pre-payment review.
 - ii. Other periodontal treatments will not be reimbursed when provided on the same date as full mouth debridement. Where other periodontal services are provided on the same day, only the full mouth debridement will be reimbursed.
 - iii. Prophylaxis (cleaning) will not be reimbursed if it is provided on the same day as full mouth debridement. Where both are provided on the same day, only the full mouth debridement will be reimbursed.
- e. Periodontal Scaling and Root Planing; Four (4) or More Teeth per Quadrant; shall be limited to once per quadrant every three (3) years.
 - i. Only covered by report. Periodontal disease must be documented. Requires prior authorization.
 - ii. Prophylaxis (cleaning) will not be reimbursed if it is provided on the same day as a periodontal scaling and root planing; four (4) or more teeth per quadrant. Where both are provided on the same day, only the periodontal scaling and root planing; four (4) or more teeth per quadrant will be reimbursed.
 - iii. No more than two (2) quadrants per day.
- f. Periodontal Scaling and Root Planing; One (1) to Three (3) Teeth per Quadrant; shall be limited to once per quadrant every three (3) years.
 - i. Only covered by report. Periodontal disease must be documented in the medical record. Requires prior authorization.
 - ii. Prophylaxis (cleaning) will not be reimbursed if it is provided on the same day as a periodontal scaling and root planing; one (1) to three (3) teeth per quadrant. Where both are provided on the same day, only the periodontal scaling and root planing; one (1) to three (3) teeth per quadrant will be reimbursed.
 - iii. No more than two (2) quadrants per day.
- g. Periodontal Maintenance; shall be limited to two (2) times per year; counts as a prophylaxis (cleaning).
 - i. Periodontal maintenance is a covered service for Child Clients age 20 or under who are at high risk of periodontal disease or for caries. Indicators of high risk of periodontal disease include:
 - 1. History of periodontal scaling and root planing; or
 - 2. History of periodontal surgery; or
 - 3. Diabetic diagnosis; or
 - 4. Pregnancy; or

-
- 5. By report when periodontal disease can be documented.
Requires prior authorization.
 - h. For child clients who are at high risk for periodontal disease as indicated above, any combination of up to four (4) prophylaxes (cleanings) or four (4) periodontal maintenance visits are allowed per year.
 - i. In all instances in which the Child Client is in acute pain or there exists acute trauma, the dentist should take the necessary steps to relieve the pain and complete the necessary emergency services. In these instances, there may not be time for prior authorization. Such emergency services shall be subject to post-treatment and pre-payment review.
9. Covered Removable Prosthetics
- a. Removable prosthetics are not covered if eight (8) or more posterior teeth (natural or artificial) are in occlusion. Anterior teeth shall be covered, irrespective of the number of teeth in occlusion.
 - b. Removable prosthetics covered include:
 - i. Removable Partial Upper Denture, Resin Based; shall be limited to one (1) time every five (5) years. Requires prior authorization.
 - ii. Removable Partial Lower Denture, Resin Based; shall be limited to one (1) time every five (5) years. Requires prior authorization.
 - iii. Removable Partial Upper Denture, Cast Metal Framework; shall be limited to one (1) time every five (5) years. Requires prior authorization.
 - iv. Removable Partial Lower Denture, Cast Metal Framework; shall be limited to one (1) time every five (5) years. Requires prior authorization.
 - v. Removable Partial Upper Denture, Flexible Base; shall be limited to one (1) time every five (5) years. Requires prior authorization.
 - vi. Removable Partial Lower Denture, Flexible Base; shall be limited to one (1) time every five (5) years. Requires prior authorization.
 - vii. Complete Upper Dentures; shall be limited to one (1) time every five (5) years. Includes initial six (6) months of relines. Requires prior authorization.
 - viii. Complete Lower Dentures; shall be limited to one (1) time every five (5) years. Includes initial six (6) months of relines. Requires prior authorization.
 - ix. Immediate Upper Dentures; shall be limited to one (1) per lifetime per patient. Includes initial six (6) months of relines. Requires prior authorization.
 - x. Immediate Lower Dentures; shall be limited to one (1) per lifetime per patient. Includes initial six (6) months of relines. Requires prior authorization.
-

- xi. Obturator Prosthesis, Surgical, Definitive and/or Modification; covered by report. Requires prior authorization.
- 10. Covered Oral Surgery, Palliative Treatment and Anesthesia
 - a. The following surgical and palliative treatments are covered:
 - i. Simple Extraction; shall be limited to one (1) time per tooth.
 - ii. Surgical Extraction; shall be limited to one (1) time per tooth.
 - iii. Extraction, Coronal Remnants, Deciduous Tooth; shall be limited to one (1) time per tooth.
 - iv. Incision and Drainage of Abscess; concurrent with extraction will be covered by report when narrative of medical necessity can be documented. Will not be reimbursed in same surgical area and on same visit as any other definitive treatment codes; except for covered services necessary for diagnosis. Such incision and drainage procedures may be subject to post-treatment and pre-payment review.
 - v. Palliative Treatment of Dental Pain; will not be reimbursed on same visit as any definitive treatment codes; except for radiographs necessary for diagnosis. Will not be reimbursed when only other service is writing a prescription.
 - vi. Deep Sedation/General Anesthesia.
 - 1. Only for Child Clients with special health care needs as that term is defined at Section 8.202.1., or when there is sufficient evidence to support medical necessity.
 - 2. Nitrous oxide will not be reimbursed if provided on the same day as deep sedation/general anesthesia, intravenous conscious sedation, or non-intravenous conscious sedation. Where multiple levels of anesthesia are provided on the same day, only the deep sedation/general anesthesia will be reimbursed.
 - vii. Nitrous Oxide; will not be reimbursed if it is provided on the same day as deep sedation/general anesthesia, intravenous conscious sedation, or non-intravenous conscious sedation. Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed.
 - viii. Intravenous Conscious Sedation.
 - 1. Only for Child Clients with special health care needs as that term is defined at Section 8.202.1., or when there is sufficient evidence to support medical necessity.
 - 2. Intravenous conscious sedation will not be reimbursed if provided on the same day as deep sedation/general anesthesia, nitrous oxide, or non-intravenous conscious sedation. Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed.

-
- ix. Non-Intravenous Conscious Sedation.
 - 1. Only for Child Clients with special health care needs as that term is defined at Section 8.202.1., or when there is sufficient evidence to support medical necessity.
 - 2. Non- intravenous conscious sedation will not be reimbursed if provided on the same day as deep sedation/general anesthesia, nitrous oxide, or intravenous conscious sedation. Where multiple levels of anesthesia are provided on the same day, only the highest level of anesthesia administered will be reimbursed.
 - b. In all instances in which the Child Client is in acute pain, the dentist should take the necessary steps to relieve the pain and complete the necessary emergency services. In these instances, there may not be time for prior authorization. Such emergency services shall be subject to post-treatment and pre-payment review.
 - c. Biopsies are covered only in instances where there is a suspicious lesion.
 - d. Removal of third molars is only covered in instances of acute pain and overt symptomatology.
 - e. Extraction of primary teeth which are close to exfoliation will not be covered.
 - i. For Child Clients who present with overt symptomatology or ectopic eruption because of an inability to extract the exfoliating teeth themselves, extraction of primary teeth may be approved subject to EPSDT guidelines.
11. Covered Hospital-Based Services
- a. Dental treatment is covered in a hospital or outpatient facility, under deep sedation or general anesthesia, only when there is medical necessity.
 - b. Under this Section 11, medical necessity, shall be limited to the following:
 - i. Patients with a documented physical, mental or medically compromising condition.
 - ii. Patients who have a dental need and for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
 - iii. Patients who are extremely uncooperative, unmanageable, anxious or uncommunicative and who have dental needs deemed sufficiently urgent that care cannot be deferred. Evidence of the attempt to manage in an outpatient setting must be provided.
 - iv. Patients who have sustained extensive orofacial and dental trauma.
 - v. Child Clients ages 6 and under who present with rampant decay.
 - c. All operating room cases require prior authorization, even if the complete treatment plan is not available.
-

- d. Consistent with the Guidelines of the American Academy of Pediatric Dentistry, the following shall be considered when contemplating treatment of a child under deep sedation or general anesthesia:
 - i. Alternative behavioral guidance modalities.
 - ii. Dental needs of the patient.
 - iii. The effect on the quality of dental care.
 - iv. The patient's emotional development.
 - v. The patient's medical status.
 - e. General anesthesia and sedation are not covered services when the patient is cooperative and requires minimal dental treatment, or when the patient has a concomitant medical condition which would make general anesthesia or sedation unsafe.
- 12. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services will be provided to Child Clients age 20 years and under if the criteria are met.

8.202.2.B. Exclusions.

- 1. Notwithstanding exceptions for EPSDT Services, the following services/treatments are not a benefit for Child Clients age 20 years and under:
 - a. Cosmetic procedures.
 - b. Crowns in the following categories:
 - i. Cosmetic crowns;
 - ii. Multiple units of crown and bridge;
 - iii. To restore vertical dimension;
 - iv. When Child Client has active and advanced periodontal disease;
 - v. When the tooth is not in occlusion; or
 - vi. When there is evidence of periapical pathology.
 - c. Implants.
 - d. Endodontic surgery.
 - e. Treatment for temporomandibular joint disorders.
 - f. Oral hygiene instruction.
 - g. Working and final treatment films for root canal treatment.
 - h. Root canals for third molars.

- i. Removal of third molars. Removal of third molars is only covered in instances of acute pain and overt symptomatology.
- j. Any service that is not listed as covered.

8.202.3 PRIOR AUTHORIZATION REQUEST

- 1. Emergency Services do not require a prior authorization and shall be subject to pre-payment review.
- 2. Prior authorizations or benefits shall be denied for reasons of poor dental prognosis, lack of dental necessity or appropriateness or because the requested services do not meet the generally accepted standard of dental care.
- 3. The following services require prior authorization:
 - a. Single crowns; core build-ups; post and cores.
 - b. Gingivectomy.
 - c. Complete, partial, and immediate dentures.
 - d. Obturators.
 - e. Scaling and root planing (periodontal maintenance).
 - f. Retreatment of root canals; prior authorization is not required for pulpal debridement in instances of acute pain.
 - g. Hospital-based services when treatment is required.

8.202.4. PROVIDER REQUIREMENTS/REIMBURSEMENT

8.202.4.A. Dental services shall only be provided by a dental professional who is enrolled with Colorado Medicaid with the exception of services rendered to Child Clients by qualified medical personnel. Providers shall only provide covered services that are within the scope of their practice.

8.202.4.B. The following billing limitations apply:

- 1. Restorations:
 - a. Tooth preparation, anesthesia, all adhesives, liners and bases, polishing and occlusal adjustments are included within the reimbursement rate for restoration. Unbundling of dental restorations for billing purposes is not allowed.
 - b. Restorations for permanent and primary teeth are paid at the same rate.
 - c. The total restorative fee for a primary tooth cannot exceed the current maximum benefit for a prefabricated stainless steel crown.
 - d. Amalgam and composite restorations are reimbursed at the same rate.

- e. Claim payment to a dental provider for one (1) or more restorations for the same tooth is limited to a total of four (4) tooth surfaces.
2. Pulpal debridement; if a dentist completes a pulpal debridement procedure, and subsequently completes a root canal on the same tooth; payment for the pulpal debridement will be subtracted from the final root canal payment.
3. Hospital procedures; payment for services performed in the operating room or outpatient facility, when scheduled for the convenience of the provider or the patient in the absence of medical necessity, will not be reimbursed.
4. In the event that two or more treatments could be used to adequately diagnose and treat a dental condition, the Provider shall use the least costly of those options in accordance with best dental practices.
5. If a procedure is not listed as covered benefit, the procedure will not be covered, unless special consideration and approval has been obtained, to reflect extenuating circumstances.
6. A client may make personal expenditures for services not covered by Medicaid and shall be charged the lower of the Medicaid Fee Schedule or submitted charges.

8.202.5 ELIGIBLE CLIENTS

Dental services described in this Section 8.202 shall apply to Child Clients age 20 years and under.

8.203 VISION SERVICES

8.203.1 Definitions

Adult Client means a Colorado Medicaid client 21 years of age or older.

Comprehensive Eye Exam means the examination, diagnosis, treatment, and management of diseases, injuries, and disorders of the visual system, the eye, and associated structures as well as identified related systemic conditions affecting the eye.

Low Vision Aid means one of a range of magnification devices that may be necessary to supplement eyeglasses for people with vision loss or low vision.

Refractive Error means a failure of the eye to focus images sharply on the retina, causing blurred vision.

8.203.2 Client Eligibility

8.203.2.A. All Colorado Medicaid clients are eligible for covered vision services, subject to the service-specific criteria and restrictions detailed in this section 8.203.

8.203.3 Provider Eligibility

8.203.3.A. Ordering, Prescribing, Referring (OPR) Providers

1. The following providers are eligible to order, prescribe, or refer vision services when enrolled with Colorado Medicaid and licensed by the Colorado Department of Regulatory Agencies, or the licensing agency of the state in which they do business:

- a. Optometrists
- b. Ophthalmologists
- c. Physicians

8.203.3.B. Rendering Providers

- 1. The following providers are eligible to render vision services when enrolled with Colorado Medicaid and licensed by the Colorado Department of Regulatory Agencies, or the licensing agency of the state in which they do business:
 - a. Optometrists
 - b. Ophthalmologists
 - c. Opticians

8.203.4 Covered Services

8.203.4.A. Examinations and Eye Care Services

- 1. Comprehensive Eye Exam (CEE)
 - a. Limited to one (1) comprehensive eye exam per client, per calendar year.
- 2. Post-Comprehensive Eye Exam Follow-Up Visit
 - a. Covered if medically necessary, as defined in section 8.076.1.8, to address a change in client's condition.
- 3. Orthoptic and Pleoptic Vision Therapy
 - a. Covered for a client 20 years of age or younger, when medically necessary, as defined in section 8.076.1.8.

8.203.4.B. Eyeglasses

- 1. Frames and Lenses – Adult Clients
 - a. Frames and lenses are covered for an Adult Client if:
 - i) Client has previously undergone eye surgery; and
 - ii) Medically necessary, as defined in section 8.076.1.8.
 - b. Covered frames and lenses for an Adult Client are limited to:
 - i) One (1) eyeglasses frame; and
 - ii) Up to two (2) lenses that are:
 - 1) Single or multi-focal;
 - 2) Clear glass or plastic; and

- 3) Without filters or coatings.
- c. Limited to one (1) pair of eyeglasses per Adult Client, per 24-month period.
- 2. Frames and Lenses – Clients 20 Years of Age or Younger
 - a. Frames and lenses are covered for a client 20 years of age or younger if:
 - i) Medically necessary, as defined in section 8.076.1.8;
 - ii) Prescribed by a provider who meets the criteria at 8.203.3.A.; and
 - iii) Purchased through a provider who meets the criteria at 8.203.3.B.
 - b. Per prescription, covered frames and lenses for a client 20 years of age or younger are limited to:
 - i) One (1) eyeglasses frame; and
 - ii) Up to two (2) lenses that are:
 - 1) Single or multi-focal; and
 - 2) Clear glass, plastic, or polycarbonate.

8.203.4.C. Contact Lenses

- 1. Contact lenses are covered for an Adult Client if:
 - a. Client meets the criteria for eyeglasses frames and lenses in section 8.203.4.B.1.a.; and
 - b. Eyeglasses are not sufficient to treat the client's refractive error.
- 2. Contact lenses are covered for a client 20 years of age or younger if:
 - a. Client meets criteria for eyeglasses frames and lenses in section 8.203.4.B.2.a.; and
 - b. Eyeglasses are not sufficient to treat the client's refractive error.

8.203.4.D. Ocular Prosthetics

Ocular prosthetics are covered for all clients when medically necessary, as defined in section 8.076.1.8.

8.203.4.E. Low Vision Aids

Low Vision Aids are covered for a client 20 years of age or younger when medically necessary, as defined at section 8.076.1.8.

8.203.4.F. Eyewear Replacement

- 1. Eyewear replacement is covered for a client 20 years of age or younger in the event of:
 - a. Loss;

- b. A change in prescription; or
 - c. Damage, if the cost to repair exceeds the cost of replacement.
- 2. Eyewear replacement for a client 20 years of age or younger is limited to the following types of eyewear:
 - a. Eyeglasses frames and lenses;
 - b. Contact lenses;
 - c. Ocular prosthetics; and
 - d. Low vision aids.
- 3. Eyewear replacement is not covered for Adult Clients.

8.203.5 Prior Authorization

8.203.5.A. Prior authorization is not required for vision services described in section 8.203.4.

8.203.6 Limitations, Exceptions, Non-Covered Services

8.203.6.A. Non-Covered Services

- 1. LASIK surgery and other eye surgeries which are not medically necessary.

8.205 MEDICAID STATEWIDE MANAGED CARE SYSTEM

8.205.1 DEFINITIONS

- 8.205.1.A. Attribution means the process by which the Department enrolls a Member with a Primary Care Medical Provider or Managed Care Organization.
- 8.205.1.B. Covered Services means the health care services defined in the contract between the Department and a Managed Care Organization or Prepaid Inpatient Health Plan that are paid through a Monthly Capitation Payment.
- 8.205.1.C., Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention or behavioral health services to result in the following:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy.
 2. Serious impairment to bodily functions.
 3. Serious dysfunction of any bodily organ or part.
- 8.205.1.D. Emergency services means covered inpatient and outpatient services that are as follows:
1. Furnished by a provider that is qualified to furnish these services.
 2. Needed to evaluate or stabilize an emergency medical condition.
- 8.205.2.E. Managed Care Organization (MCO) shall mean an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR 438.2, and that is:
1. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR 489; or
 2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary of the U.S. Department of Health and Human Services to also make the services it provides to its Medicaid members as accessible (in terms of timelines, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and meets the solvency standards of 42 CFR 438.116.
- 8.205.1.F. Medicaid Statewide Managed Care System, also known as the Accountable Care Collaborative, means any Managed Care Organization, Primary Care Case Management Entity, or Prepaid Inpatient Health Plan established under the State authorities established in Title 25.5, Article 5, Part 4, C.R.S. and under the federal authority established in 42 C.F.R. Part 438 and approved by the Centers for Medicare and Medicaid Services (CMS).
- 8.205.1.G. Member means any person enrolled in the Medicaid Statewide Managed Care System.

8.205.1.H. Prepaid Inpatient Health Plan (PIHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.205.1.I. Primary Care Case Management Entity (PCCM Entity) means an entity contracted with the state department to furnish case management services, including the coordination and monitoring of primary health care services, as defined in 42 CFR § 438.2.

8.205.1.J. Primary Care Medical Provider (PCMP) means a primary care provider contracted with PCCM Entity to serve as a medical home for members.

8.205.1.K. Utilization Management means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.

8.205.2 CLIENT ELIGIBILITY

8.205.2.A. A Medicaid Client with full Medicaid benefits must be enrolled into the Medicaid Statewide Managed Care System, with the exception of the individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE) as defined in Section 8.497.

8.205.2.B. The following individuals are not eligible for enrollment in the Medicaid Statewide Managed Care System:

1. Qualified Medicare Beneficiary only (QMB-only).
2. Qualified Disabled and Working Individuals (QDWI)
3. Qualified Individuals 1 (QI 1).
4. Special Low Income Medicare Beneficiaries (SLMB).
5. Undocumented immigrants.
6. Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE).
7. Individuals between ages 21 and 64 who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.
8. Individuals who are incarcerated.
9. Individuals while determined presumptively eligible for Medicaid.

8.205.3 MEMBER RIGHTS AND PROTECTIONS

8.205.3.A. A Member enrolled in a PCCM Entity, MCO, or PIHP has the following rights and protections:

1. To be treated with respect and with due consideration for the Member's dignity and privacy.
2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

3. To participate in decisions regarding the Member's health care, including the right to refuse treatment and the right to a second opinion.
4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
5. To obtain family planning services and family planning-related services directly from any provider duly licensed or certified to provide such services without regard to enrollment in a PCCM Entity, MCO, or PIHP, without referral.
6. To request and receive a copy of the Member's medical records and to request that they be amended or corrected, as specified in 45. CFR Part 164.
7. To select a PCMP from those available in the PCCM Entity or MCO network.
8. To request any change of PCMP in a PCCM Entity network from the Department or its designee.
9. To select or request a change of a provider from those providers available in the MCO or PIHP provider network.
10. To have access to written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages. All materials shall be written in English and Spanish, or any other prevalent language, as directed by the Department or as required by 42 CFR 438.10.
11. To have oral interpretation available in all languages and written translation available in each prevalent non-English language at no cost to any Member.
12. To exercise the Member's rights without any adverse effect on the way the Member is treated.

8.205.4 MEMBER ENROLLMENT AND DISENROLLMENT

- 8.205.4.A. Enrollment in the Medicaid Statewide Managed Care System is mandatory for eligible Members.
- 8.205.4.B. Members enrolled into the Medicaid Statewide Managed Care System are attributed to a PCMP or MCO.
 1. Members may be attributed to an MCO in accordance with the Department's member enrollment policy that takes into consideration the following:
 - a. County of residence.
 - i. Members residing in Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco counties may be attributed to the MCO operated by or under the control of Rocky Mountain Health Plans.
 - ii. Members residing in Adams, Arapahoe, Denver, and Jefferson Counties may be attributed to the MCO operated by or under the control of Denver Health and Hospital Authority.
 - b. Member's age.

- c. Member's Medicaid aid category.
- 2. Members will be attributed to a PCMP based on factors that include Member choice, Member utilization history, provider capacity, and geographic location in accordance with the Department's member enrollment policy in the following instances:
 - a. The Member resides in a county that is not covered by an MCO.
 - b. The Member opts out of enrollment in an MCO.
- 3. Members may change their attribution to a PCMP by contacting the Department or its designee. Any change in attribution to a PCMP is effective the first day of the month following the member's formal submission of the change request to the Department or its designee.
- 4. Members may change their attribution to an MCO as specified in 8.205.5. H, I, J, and K.
- 8.205.4.C. Members attributed to a PCMP are assigned to a PCCM Entity/PIHP based on the PCMP's contract with a PCCM Entity/PIHP.
- 8.205.4.D. Members attributed to an MCO are assigned to the PIHP contracted with the MCO.
- 8.205.4.E. Child and youth Members determined eligible for Medicaid as a result of a dependency and neglect action resulting in out-of-home placement pursuant to article 2 of title 19 C.R.S. must be assigned to the PCCM Entity and PIHP that cover the county with jurisdiction over the action.
 - 1. The Department or its designee may change the child or youth Member's PCCM Entity and PIHP assignment only at the request of the county with jurisdiction over the action or by the child's or youth's legal guardian.
- 8.205.4.F. Members who are disenrolled from a PCCM Entity, MCO, or PIHP for a period of two (2) months or less due to loss of eligibility shall be reenrolled into the same program upon regaining eligibility within the two (2) month period.
- 8.205.4.G. A Member who is enrolled with an MCO remains assigned to that MCO for a period of twelve (12) months except as otherwise provided in these rules.
- 8.205.4.H. A Member may request disenrollment from their MCO without cause during the ninety (90) days following the date of their initial enrollment or the date the Department or its designee sends the notice of enrollment, whichever is later.
- 8.205.4.I. A Member may request disenrollment without cause at least every twelve (12) months after the date of initial enrollment with an MCO.
- 8.205.4.J. A Member may request disenrollment when the Department imposes intermediate sanctions as set forth in the Department's contract with the MCO.
- 8.205.4.K. A Member may request disenrollment from an MCO for cause at any time. Cause shall be defined as any of the following:
 - 1. The Member moves out of the MCO service area.
 - 2. The MCO does not, because of moral or religious objections, cover the service the Member needs.

3. The Member needs related services to be performed at the same time and not all related services are available within the MCO network, and the Member's provider determines that receiving the services separately would subject the Member to unnecessary risk.
 4. The Department or its designee unintentionally enrolls a Member into the wrong plan.
 5. Poor quality of care, as documented by the Department.
 6. Lack of access to covered services, as documented by the Department.
 7. Lack of access to providers experienced in dealing with the Member's health care needs, as documented by the Department.
 8. The Member's primary care provider leaves the MCO.
 9. Other reasons satisfactory to the Department.
- 8.205.4.L. For Members who are unable to make decisions for themselves, a family member, legal guardian or designated advocate shall be included in all decision-making concerning enrollment and disenrollment of the Member.

8.205.5 DISMISSAL OF MEMBER BY A PROVIDER

- 8.205.5.A. Providers, excluding safety net providers, participating in a PCCM Entity, MCO, or PIHP may dismiss an enrolled Member from their practice for cause at any time. Cause shall be defined as any of the following:
1. A documented, ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet any other Member responsibilities.
 2. A documented ongoing pattern of failure to follow the recommended treatment plan or medical instructions.
 3. The provider cannot provide the level of care necessary to meet the Member's needs.
 4. The Member and /or Member's family is abusive to provider and/or staff.
 5. The provider moves out of the service area.
 6. Other reasons approved by the Department.
- 8.205.5.B. Providers must take the following steps prior to dismissing a Member from their practice:
1. The provider shall give no less than 45 days notice to both the Member and the PCCM Entity, MCO or PIHP.
 2. For Members with behavioral health needs who are at risk of dismissal, the provider must make a referral for care coordination to the Member's MCO, PIHP, or PCCM Entity prior to giving written notice of dismissal.
 3. The provider shall give the Member a reasonable opportunity to find substitute care and information necessary to obtain the patient's medical records;
- 8.205.5.C. The PCCM Entity, MCO or PIHP shall respond within 48 hours of any request to coordinate Member access to a new provider.

8.205.6 ESSENTIAL COMMUNITY PROVIDERS

8.205.6.A In order to be eligible for designation as an Essential Community Provider, the following health care providers shall be determined to have historically served medically needy or medically indigent patients and demonstrated a commitment to serve low-income and medically indigent populations who make up a significant portion of their patient population or, in the case of a sole community provider, serve the medically indigent patients within their medical capability:

1. Disproportionate share hospitals.
2. Local county and district health departments, county nursing services and regional health department operating pursuant to Title 25, C.R.S., as amended.
3. Federally Qualified Health Centers (FQHCs).
4. School based health centers that can verify that 25% of students enrolled in the school are at or below 185% of the Federal Poverty Level and that services are offered to the entire student population enrolled in the school without regard to the patient's ability to pay.
5. Family Medicine Residency Training Programs that can verify that 25 % of the patients served are at or below 185% of the Federal Poverty Level.
6. Rural Health Clinics that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
7. State certified Title X Family. Planning Agencies that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
8. Sole community providers that are not located within a metropolitan statistical area, as designated by the U.S. Office of Management and Budget, and in whose community there is no other similar type of health care and the provider can verify that it provides health care services to patients below 185% of the Federal Poverty Level within its medical capability.
9. New health care providers operating under a sponsoring or participating entity that qualifies as an Essential Community Provider.
10. Health care providers that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

8.205.6.B. In order to be eligible for designation as an Essential Community Provider, the provider shall waive charges or charge for services on a sliding scale for patients/families at or below 185% of the Federal Poverty Level.

8.205.6.C. Health care providers, except those set forth a 8.206.1(1) through (3), who seek to be designated as an Essential Community Provider, shall submit their application, including a copy of their sliding fee scale to the Department.

8.205.7 QUALIFIED PHARMACY PROVIDERS

8.205.7.A. An MCO shall contract with qualified pharmacy providers in a manner permitting a nursing facility to continue to comply with federal Medicaid requirements of participation.

8.205.7.B. A qualified pharmacy provider shall meet all of the following requirements:

1. Employ, on a full-time basis, a pharmacist licensed by the State of Colorado.
2. Demonstrate a capability of procuring, preparing, dispensing and distributing pharmaceutical products in an institutional setting.
3. Demonstrate a capability of monitoring Members on an ongoing basis to identify, prevent and resolve drug-related problems including, but not limited to, the monitoring of drug-drug interactions and drug-allergy interactions.
4. Provide pharmaceutical consulting services twenty-four (24) hours per day.
5. Perform medication-use assessments with the assistance of a pharmacist licensed by the State of Colorado at least once each month. Such assessments shall be Member-centered, ensuring that the Member's medication regimen meets his or her needs.
6. Participate with the Member's physicians, nurses, dieticians and other health care professionals in inter-disciplinary care planning.
7. Provide continuous pharmaceutical care and services to Members twenty-four (24) hours per day every day.
8. Reasonably respond to emergency situations and maintain an emergency kit registered with the Colorado State Board of Pharmacy at each nursing home.
9. Utilize appropriate unit dose or unit of issue distribution systems to ensure that Members receive proper medications, at the proper time, and at the proper dosage.
10. Demonstrate its capability to provide physician orders and medication administration records on a monthly basis.

8.205.8 PERSONS WITH SPECIAL HEALTH CARE NEEDS

8.205.8.A. Persons with Special Health Care Needs shall mean persons having ongoing health conditions that

1. Have a biologic, psychologic or cognitive basis;
2. Have lasted or are virtually certain to last for at least one year; and
3. Produce one or more of the following sequelae:
 - a. Significant limitation in areas of physical, cognitive or emotional function;
 - b. Dependency on medical or assistive devices to minimize limitation of function or activities;
 - c. In addition, for children:
 - (i) Significant limitation in social growth or developmental function;
 - (ii) Need for psychologic, educational, medical or related services over and above the usual for the child's age; or
 - (iii) Special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.

8.205.9 STATEWIDE SYSTEM OF COMMUNITY BEHAVIORAL HEALTH CARE

8.205.9.A The Medicaid Statewide Managed Care System must include PIHPs to administer a statewide system of community behavioral health care.

8.205.9.B. The following are required services of the statewide system of community behavioral health care:

1. Inpatient Behavioral Health Services -- A program in which the Member receives services in a hospital or health care facility 24 hours a day.
 - a. Inpatient Psychiatric Services -- A program of psychiatric care in which the Member remains 24 hours a day in a psychiatric hospital, State Institute for Mental Disease (IMD), or other facility licensed as a hospital or Psychiatric Residential Treatment Facility by the State.
 - i. Members under age 21 and members 65 years of age or older may receive services in an IMD.
 - ii. Members ages 21-64 are excluded from receiving services in an IMD for more than 15 days within a month.
 - b. Residential and Inpatient Substance Use Disorder Services
 - i. Inpatient Substance Use Disorder Services – Substance use disorder services that provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting. American Society of Addiction Medicine level 4 services are reimbursed fee for service and are not covered by the PIHP as part of the statewide system of community behavioral health care.
 - ii. Residential Substance Use Disorder Services – Substance use disorder services that are delivered in settings that provide 24-hour structure, support and clinical interventions for patients. These services are appropriate for Members who require time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment. Higher levels of residential treatment provide safe, stable living environments for Members who need them to establish or maintain their recovery apart from environments that promote continued use in the community.
2. Outpatient Services -- A program of care in which the Member receives services in a hospital or other health care facility, but does not remain in the facility 24 hours a day, including:
 - a. Physician Services, including psychiatric care – Behavioral health services provided within the scope of practice of medicine as defined by State law.
 - b. Rehabilitative Services – Any remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under State law, for maximum reduction of behavioral/emotional disability and restoration of a Member to the Member's best possible functional level, including:

-
- i. Individual Behavioral Health Therapy - Therapeutic contact with one Member of more than 30 minutes, but no more than two (2) hours.
 - ii. Individual Brief Behavioral Health Therapy- Therapeutic contact with one Member of up to and including 30 minutes.
 - lii Group Behavioral Health Therapy- Therapeutic contact with more than one Member, of up to and including two (2) hours.
 - iv. Family Behavioral Health Therapy– Therapeutic contact with a Member and family member(s), or other persons significant to the Member, for improving Member-family functioning. Family behavioral health therapy is appropriate when intervention in the family interactions is expected to improve the Member’s emotional/behavioral health. The primary purpose of family behavioral health therapy is treatment of the Member.
 - v. Behavioral Health Assessment – Clinical assessment of a Member by a behavioral health professional that determines the nature of the Member’s problem(s), factors contributing to the problem(s), a Member’s strengths, abilities and resources to help solve the problem(s), and any existing diagnoses.
 - vi. Pharmacologic Management – Monitoring of medications prescribed and consultation provided to Members by a physician or other medical practitioner authorized to prescribe medications as defined by State law, including associated laboratory services, as indicated.
 - vii. Outpatient Day Treatment – Therapeutic contact with a Member in a structured, non-residential program of therapeutic activities lasting more than four (4) hours but less than twenty-four (24) hours per day. Services include assessment and monitoring; individual/group/family therapy; psychological testing; medical/nursing support; psychosocial education; skill development and socialization training focused on improving functional and behavioral deficits; medication management; expressive and activity therapies; and coordination of needed services with other agencies. When provided in an outpatient hospital program, may be called “partial hospitalization.”
 - viii. Intensive Outpatient Substance Use Disorder Services – Therapeutic contact with a member to help the member achieve changes in their alcohol and/or other drug use. Intensive outpatient treatment services are delivered with greater frequency than standard outpatient services. This level of care is appropriate for patients who have more complex needs. Allowable services include substance use disorder assessment, individual and family therapy, group therapy, and alcohol/drug screening counseling.
 - ix. Emergency/Crisis Services - Services provided during a behavioral health emergency which involve unscheduled, immediate, or special interventions in response to crisis situation with a Member, including associated laboratory services, as indicated.
3. Targeted Case Management – Case management services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.
-

4. School-Based Behavioral Health Services - Behavioral health services provided to school-aged children and adolescents on-site in their schools, with the cooperation of the schools.
5. Drug Screening and Monitoring – Substance use disorder counseling services provided along with screening results to be discussed with client.
6. Detoxification Services – Services relating to detoxification including all of the following: Physical assessment of detox progression including vital signs monitoring; level of motivation assessment for treatment evaluation; provision of daily living needs (includes hydration, nutrition, cleanliness and toiletry); safety assessment, including suicidal ideation and other behavioral health issues.
7. Medication-Assisted Treatment – Administration of Methadone or another approved controlled substance to an opiate-dependent person for the purpose of decreasing or eliminating dependence on opiate substances.
8. Alternative behavioral health services—Administration of non-traditional, community-based services not available through the State Plan but authorized through the Department's 1915(b) waiver with the Centers for Medicare and Medicaid Services.
 - a. Assertive Community Treatment (ACT) – Comprehensive, locally-based, individualized treatment for adults with serious behavioral health disorders, that is available 24 hours a day, 365 days a year. The ACT team actively engages Members in their community to develop skills and monitor status, rather than function as an office-based team. Services include case management, initial and ongoing behavioral health assessment, psychiatric services, employment and housing assistance, family support and education, and substance use disorders services.
 - b. Clubhouse and Drop-in Center services – Peer support services for people who have behavioral health disorders, provided in a Clubhouse or Drop-In Center setting. Clubhouse participants may use their skills for clerical work, data input, meal preparation, providing resource information and outreach to clients. Drop-in Centers offer planned activities and opportunities for individuals to interact socially, promoting and supporting recovery.
 - c. Intensive Case Management -- Community-based services averaging more than one hour per week, provided to adults with serious behavioral health disorders who are at risk of a more intensive 24 hour placement and who need extra support to live in the community. Services are assessment, care plan development, multi-system referrals, assistance with wraparound and supportive living services, monitoring and follow-up. Intensive case management may be provided to children/youth under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

- d. Mental Health Residential Services – Twenty-four (24) hour care, excluding room and board, provided in a non-hospital, non-nursing home setting, appropriate for Members whose mental health issues and symptoms are severe enough to require a 24-hour structured program but do not require hospitalization. Services are provided in the setting where the client is living, in real-time, with immediate interventions available as needed. Clinical interventions are assessment and monitoring of mental and physical health status; assessment and monitoring of safety; assessment of/support for motivation for treatment; assessment of ability to provide for daily living needs; observation and assessment of group interactions; individual, group and family therapy; medication management; and behavioral interventions. Residential services may be provided to children/youth under EPSDT.
- e. Prevention/Early Intervention Services – Proactive efforts to educate and empower individuals to choose and maintain healthy life behaviors and lifestyles that promote positive behavioral health. Services include behavioral health screenings; educational programs promoting safe and stable families; senior workshops related to aging disorders; and parenting skills classes.
- f. Recovery Services – Community-based services that promote self-management of behavioral health symptoms, relapse prevention, treatment choices, mutual support, enrichment, rights protection, social supports. Services are peer counseling and support services, peer-run drop-in centers, peer-run employment services, peer mentoring, consumer and family support groups, warm lines, and advocacy services.
- g. Respite Care – Temporary or short-term care of a child, youth or adult client provided by adults other than the birth parents, foster/adoptive parents, family members or caregivers that the Member normally resides with. Respite is designed to give the caregivers some time away from the Member to allow them to emotionally recharge and become better prepared to handle normal day-to-day challenges. Respite care providers are specially trained to serve individuals with behavioral health issues.
- h. Vocational -- Services designed to help adult and adolescent clients who are ineligible for state vocational rehabilitation services to gain employment skills and employment. Services are skill and support development interventions, educational services, vocational assessment, and job coaching.

8.205.9.C. The PIHPs must offer Members an initial or subsequent nonurgent behavioral health care visit where medically necessary and at appropriate therapeutic intervals in compliance with C.R.S. § 25.5-5-402 (3)(g).

8.205.10 UTILIZATION MANAGEMENT

8.205.10.A. The MCOs and PIHPs must ensure Covered Services delivered to Members are Medically Necessary as defined in Section 8.076.1.8 as well as Section 8.280 for Members under 21 years of age, delivered in the least restrictive setting, and most likely to address the Member's health care needs by employing Utilization Management best practices.

- 1. If it is determined that the Member does not meet criteria of Medical Necessity or the Member has a diagnosis not covered by the capitated payment arrangement, MCOs and PIHPs must inform the Member about how other appropriate Medicaid State Plan services may be obtained and coordinate referrals to appropriate providers within the region within 48 hours of request from the Member, a family member, legal guardian or designated advocate.

- 8.205.10.B. Utilization Management practices shall align with the following guidelines:
1. Establish and regularly update Utilization Management policies and procedures for evaluating the clinical appropriateness, efficacy, or efficiency of Covered Services, referrals, procedures or settings in accordance with the most recent national and industry standards or guidelines and with federal and department rules and regulations.
 2. Ensure Utilization Management policies and procedures are designed in compliance with 42 CFR 438. Part 2.
 3. Design and implement Utilization Management policies and procedures in compliance with the federal Mental Health Parity and Addiction Equity Act requirements defined in 42 CFR 438 Subpart K, including the application of financial requirements, treatment limitations, and non-quantitative treatment limitations, as well as the process for determining access to out-of-network providers.
 4. Appropriately incorporate use of prior authorization and continued stay reviews for residential and inpatient behavioral health services that are not for treatment of an Emergency Medical Condition to ensure that the services requested or furnished are medically necessary and sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
 - a. Utilize the American Society of Addiction Medicine criteria to determine medical necessity for residential and inpatient substance use disorder treatment services.
 - b. Engage in care coordination and discharge planning to appropriately transition members across the continuum of care.
 5. Make Utilization Management decision-making criteria available to members and providers upon request.
 6. Designate an appropriately licensed medical professional to provide oversight and evaluation of the Utilization Management policies and activities.
 7. Establish standards for Utilization Management personnel to consult with the ordering provider prior to denial or limitation of requested/provided services.
 8. Ensure Utilization Management processes do not impede timely access to services.
- 8.205.10.C. The MCOs and PIHPs must ensure that the services requested or furnished are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
- 8.205.10.D. The PIHPs must cover all medically necessary Covered Services for covered behavioral health diagnoses under the Capitated Behavioral Health Benefit, regardless of any co-occurring conditions.
- 8.205.10.E. The MCOs and PIHPs must not deny a Covered Service based solely on the Member having a diagnosis of a co-occurring intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury.
- 8.205.10.F. The MCOs and PIHPs must not require prior authorization for the non-pharmaceutical components of medication-assisted treatment.

8.205.10.G. The MCOs must not impose any prior authorization requirements or step therapy requirements as a prerequisite to authorizing coverage for any prescription medication approved by the Food and Drug Administration for the treatment of substance use disorders.

8.205.10.H. The MCOs and PIHPs must coordinate State Plan covered services that are paid fee-for-service.

8.205.10.I. The MCOs and PIHPs must have a grievances and appeals process as specified in Section 8.209.

8.205.11 EMERGENCY SERVICES

8.205.11.A. The MCOs and PIHPs must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO or PIHP, to the extent that services required to treat an emergency medical condition fall within the scope of services for which the MCO or PIHP is responsible.

8.205.11.B. The MCOs and PIHPs may not deny payment for treatment obtained under either of the following circumstances:

1. A Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition in 8.205.1.C of this section.
2. A representative of the MCO or PIHP instructs the Member to seek emergency services.

8.205.11.C. The MCOs and PIHPs may not:

1. Limit what constitutes an emergency medical condition with reference to of the definition in 8.205.1.C of this section, on the basis of lists of diagnoses or symptoms, except to the extent that services required to treat an emergency medical condition fall outside the scope of the services for which the MCO and PIHP is responsible; and
2. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's primary care provider, MCO, PIHP, or applicable State entity of the Member's screening and treatment within 10 calendar days of presentation for emergency services.

8.205.11.D. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

8.209 MEDICAID MANAGED CARE GRIEVANCE AND APPEAL PROCESSES

8.209.1 GENERAL PROVISIONS

Medicaid members or their Designated Client Representatives enrolled in Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), or Prepaid Ambulatory Health Plans (PAHPs) may access and utilize the Medicaid Managed Care Grievance and Appeal Systems. The Grievance and Appeal Systems shall include a Grievance process and an Appeal process for handling Grievances and Appeals at the MCO, PIHP, or PAHP level and access to the State Fair Hearing process for Appeals.

8.209.2 DEFINITIONS

8.209.2.A. Adverse Benefit Determination shall mean:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit;
2. The reduction, suspension or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the timeframes provided in § 8.209.4 below;
6. The denial of a Medicaid member's request to exercise his or her right to obtain services outside the network for members in rural areas with only one MCO; or
7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

8.209.2.B. Appeal shall mean, for the purposes of this Section 8.209 only, a request for review by an MCO, PIHP, or PAHP of an Adverse Benefit Determination.

8.209.2.C. Designated Client Representative shall mean any person, including a treating health care professional, authorized in writing by the member or the member's legal guardian to represent his or her interests related to complaints or Appeals about health care benefits and services.

8.209.2.D. Grievance shall mean an oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights.

8.209.2.E. Managed Care Organization (MCO) shall mean an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR 438.2, and that is:

1. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR 489; or

2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary of the U.S. Department of Health and Human Services to also make the services it provides to its Medicaid members as accessible (in terms of timelines, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and meets the solvency standards of 42 CFR 438.116.

8.209.2.F. Prepaid Inpatient Health Plan (PIHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.209.2.G. Prepaid Ambulatory Health Plan (PAHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; does not provide, arrange for, or otherwise has a responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.209.2.H. State Fair Hearing shall mean the formal adjudication process for Appeals described at 10 CCR 2505-10, §8.057.

8.209.3 GRIEVANCE AND APPEAL SYSTEM

8.209.3.A. The Grievance and Appeal System means the processes the MCO, PIHP, and PAHP implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

8.209.3.B. The MCO, PIHP, or PAHP shall provide a Department-approved description of the Grievance, Appeal and State Fair Hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the MCO, PIHP, or PAHP. The description shall include:

1. The member's right to request a State Fair Hearing after the MCO, PIHP, or PAHP has made a determination on a member's Appeal, which is adverse to the member.
 - a. The method to obtain a hearing
2. The member's right to file Grievances and Appeals.
3. The requirements and timeframes for filing Grievances and Appeals.
4. The availability of assistance in the filing process.
5. The toll-free numbers that the member can use to file a Grievance or an Appeal by telephone.
6. The fact that, when requested by a member:
 - a. Benefits will continue if the member files an Appeal or a request for State Fair Hearing within the timeframes specified for filing; and
 - b. The member may be required to pay the cost of services furnished while the Appeal is pending if the final decision is adverse to the member.

8.209.3.C. The MCO, PIHP, or PAHP shall maintain record of Grievances and Appeals and submit a quarterly report to the Department. The record of each Grievance and Appeal shall include:

1. A general description of the reason for the Grievance or Appeal;
2. The date the Grievance or Appeal was received;
3. The date of each review, or if applicable, review meeting;
4. The resolution at each level of the Grievance or Appeal, if applicable;
5. The date of resolution of the Grievance or Appeal; and
6. The name of the member for whom the Grievance or Appeal was filed.

8.209.4 APPEAL PROCESS

8.209.4.A. Notice of Adverse Benefit Determination

1. The MCO, PIHP, or PAHP shall send the member written notice for each Adverse Benefit Determination. The notice shall be in writing and shall be available in English and the prevalent non-English languages spoken by members throughout the State. "Prevalent" means a non-English language spoken by a significant number or percentage of members in the service area as identified by the State.
2. The notice shall state the following:
 - a. The Adverse Benefit Determination the MCO, PIHP, or PAHP or its contractor has taken or intends to take;
 - b. The reasons for the Adverse Benefit Determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's Adverse Benefit Determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;
 - c. The member's or the Designated Client Representative's right to file an MCO, PIHP, or PAHP Appeal;
 - d. The date the Appeal is due;
 - e. The member's right to request a State Fair Hearing after receiving notice that the adverse benefit determination is upheld;
 - f. The procedures for exercising the right to a State Fair Hearing;
 - g. The circumstances under which expedited resolution is available and how to request it;
 - h. The member's right to have benefits continue pending resolution of the Appeal, and how to request that benefits be continued; and
 - i. The circumstances under which the member may be required to pay the cost of these services.

3. The MCO, PIHP, or PAHP shall mail the notice of Adverse Benefit Determination within the following timeframes:
 - a. For termination, suspension or reduction of previously authorized Medicaid covered services, at least ten (10) calendar days before the date of Adverse Benefit Determination, except in the following circumstances:
 - i) The MCO, PIHP, or PAHP may shorten the period of advance notice to five (5) calendar days for the date of Adverse Benefit Determination if:
 - 1) The MCO, PIHP, or PAHP has facts indicating probable fraud by the member; and
 - 2) The facts have been verified, if possible, through secondary sources.
 - ii) The MCO, PIHP, or PAHP may mail notice not later than the date of Adverse Benefit Determination if:
 - 1) The MCO, PIHP, or PAHP has factual information confirming the death of the member;
 - 2) The MCO, PIHP, or PAHP receives a clear written statement signed by the member stating that:
 - a) The member no longer wishes services; or
 - b) Gives information that requires termination or reduction of services and indicates that the member understands that this is the result of supplying the information;
 - iii) The member has been admitted to an institution where the member is ineligible under the plan for further services;
 - iv) The member's whereabouts are unknown and the post office returns mail directed to him or her indicating no forwarding address;
 - v) The MCO, PIHP, or PAHP establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;
 - vi) A change in the level of medical care is prescribed by the member's physician;
 - vii) The notice involves an Adverse Benefit Determination made with regard to the preadmission screening requirements of 1919(e) (7) of the Social Security Act; or
 - viii) Notice may be made as soon as practicable before transfer or discharge when:
 - 1) The safety of individuals in the facility would be endangered;
 - 2) The health of individuals in the facility would be endangered;

-
- 3) The resident's health improves sufficiently to allow a more immediate transfer or discharge;
 - 4) An immediate transfer or discharge is required by the resident's urgent medical needs; or
 - 5) A resident has not resided in the facility for 30 days.
- b. For denial of payment, at the time of any Adverse Benefit Determination affecting the claim.
 - c. For standard service authorization decisions that deny or limit services, within ten (10) calendar days. For expedited service authorizations, within seventy-two (72) hours.
 - i) If the MCO, PIHP, or PAHP extends the timeframe for making a service authorization decision, it must give the member written notice of the reason for extending the timeframe and inform the member of the right to file a Grievance to disagree with the timeframe extension.
 - ii) The MCO, PIHP, or PAHP must carry out its determination as expeditiously as the member's health condition requires, and no later than the date the extension expires.
 - d. For service authorization decisions not reached within the timeframes specified (which constitutes a denial and is thus an adverse benefit determination), on the date the timeframes expire.
- 8.209.4.B. The member of an MCO, PIHP, or PAHP shall file an Appeal within sixty(60) calendar days from the date of the MCO's, PIHP's, or PAHP's notice of Adverse Benefit Determination.
- 8.209.4.C. The MCO, PIHP, or PAHP shall give members reasonable assistance in completing any forms required by the MCO, PIHP, or PAHP, putting oral requests for a State Fair Hearing into writing and taking other procedural steps, including, but not limited to, providing interpretive services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- 8.209.4.D. The MCO, PIHP, or PAHP shall send the member written acknowledgement of each Appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution.
- 8.209.4.E. The MCO, PIHP, or PAHP shall ensure that the individuals who make decisions on Appeals are individuals who:
1. Were not involved in any previous level of review or decision-making, nor a subordinate of any such individual,
 2. Who have the appropriate clinical expertise, as determined by the Department, in treating the member's condition or disease if deciding any of the following: an Appeal of a denial that is based on lack of medical necessity, a Grievance regarding denial of expedited resolution of an Appeal, or a Grievance or Appeal that involves clinical issues, and
 3. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
-

-
- 8.209.4.F. The MCO, PIHP, or PAHP shall accept Appeals orally or in writing.
- 8.209.4.G. The MCO, PIHP, or PAHP shall provide the member a reasonable opportunity to present evidence, and legal or factual arguments, in person as well as in writing. The MCO, PIHP, or PAHP shall inform the member of the limited time available in the case of expedited resolution.
- 8.209.4.H. The MCO, PIHP, or PAHP shall provide the member and the Designated Client Representative opportunity, before and during the Appeal process, to examine the member's case file, including medical records and any other documents and records considered during the Appeal process.
- 8.209.4.I. The MCO, PIHP, or PAHP shall include as parties to the Appeal, the member and the Designated Client Representative or the legal representative of a deceased member's estate.
- 8.209.4.J. The MCO, PIHP, or PAHP shall resolve each Appeal, and provide notice as expeditiously as the member's health condition requires, not to exceed the following:
1. For standard resolution of an Appeal and notice to the affected parties, ten (10) working days from the day the MCO, PIHP, or PAHP receives the Appeal.
 2. For expedited resolution of an Appeal and notice to affected parties, seventy-two (72) hours after the MCO, PIHP, or PAHP receives the Appeal.
- 8.209.4.K. The MCO, PIHP, or PAHP may extend timeframes for the resolution of Appeals by up to fourteen (14) calendar days:
1. If the member requests the extension; or
 2. The MCO, PIHP, or PAHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO, PIHP, or PAHP shall:
 - a. Make reasonable efforts to give the member prompt oral notice of the delay.
 - b. Within 2 calendar days, give the member prior written notice of the reason for delay if the timeframe is extended and informs the member of their right to file a grievance if the member disagrees with the extension.
- 8.209.4.L. The MCO, PIHP, or PAHP shall notify the member in writing of the resolution of an Appeal. For notice of an expedited resolution, the MCO, PIHP, or PAHP shall also make reasonable efforts to provide oral notice.
- 8.209.4.M. The written notice shall include the results of the disposition/resolution process and the date it was completed.
1. For Appeals not resolved wholly in favor of the member, the written notice shall include:
 - a. The right to request a State Fair Hearing and how to do so;
 - b. The right to request and to receive benefits while the hearing is pending, and how to make the request; and
 - c. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's Appeal determination.
-

- 8.209.4.N. The member of an MCO, PIHP, or PAHP shall exhaust the MCO, PIHP, or PAHP level Appeal process before requesting a State Fair Hearing. The member shall request a State Fair Hearing within one hundred and twenty (120) calendar days from the date of the MCO's, PIHP's, or PAHP's notice of Appeal determination.
- 8.209.4.O. If the MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements regarding resolution and notification of an Appeal, the member is deemed to have exhausted the Appeals process and may request a State Fair Hearing.
- 8.209.4.P. In cases where the parent or guardian of a member submits a request for a third-party review to the Department of Human Services under 27-67-104 C.R.S. of the Child Mental Health Treatment Act, the member, parent or guardian and the MCO or PIHP shall have the right to request a State Fair Hearing. The request for the State Fair Hearing shall be submitted to the Division of Administrative Hearings within thirty (30) calendar days from the date of the determination. The State Fair Hearing shall be considered a member Appeal.
- 8.209.4.Q. The MCO, PIHP, or PAHP shall establish and maintain an expedited review process for Appeals when the MCO, PIHP, or PAHP determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.
- 8.209.4.R. The MCO, PIHP, or PAHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's Appeal.
- 8.209.4.S. If the MCO, PIHP, or PAHP denies a request for expedited resolution, it shall transfer the Appeal in the timeframe for standard resolution, make reasonable effort to give the member prompt oral notice of the denial and send a written notice of the denial for an expedited resolution within two (2) calendar days and inform the member of the right to file a grievance if the member disagrees with the decision to deny the expedited review.
- 8.209.4.T. The MCO, PIHP, or PAHP shall, consistent with federal law, provide for the continuation of benefits while the MCO, PIHP, or PAHP level Appeal and the State Fair Hearing are pending if:
1. The member:
 - a. Files for continuation of services (a) within ten (10) calendar days of the MCO, PIHP, or PAHP sending the notice of Adverse Benefit Determination, or (b) on or before the intended date of the MCO's, PIHP's, or PAHP's proposed Adverse Benefit Determination, whichever is later;
 - b. Files the request for the appeal within 60 calendar days following the notice of adverse benefit determination.
 2. The Appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
 3. The services were ordered by an authorized provider;
 4. The original period covered by the original authorization has not expired; and
 5. The member requests extension of benefits.

8.209.4.U. If at the member's request, the MCO, PIHP, or PAHP continues or reinstates the member's benefits while the Appeal is pending, the benefits shall be continued until one of the following:

1. The member withdraws the Appeal.
2. The member fails to request a State fair hearing and continuation of benefits (services) within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse appeal resolution.
3. A State Fair Hearing office issues a final agency decision adverse to the member.

8.209.4.V. If the final resolution of the Appeal upholds the MCO's, PIHP's, or PAHP's Adverse Benefit Determination, the MCO, PIHP, or PAHP may recover the cost of the services furnished to the member while the Appeal is pending to the extent that the services were furnished solely because of the requirements of this rule.

8.209.4.W. If the final resolution of the Appeal reverses the MCO's, PIHP's, or PAHP's Adverse Benefit Determination to deny, limit or delay services that were not furnished while the Appeal was pending, the MCO, PIHP, or PAHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

8.209.4.X. If the final resolution of the Appeal reverses the MCO's, PIHP's, or PAHP's Adverse Benefit Determination to deny authorization of services and the member received the services while the Appeal was pending, the MCO, PIHP, or PAHP must pay for those services.

8.209.5 GRIEVANCE PROCESS

8.209.5.A. The member of the MCO, PIHP, or PAHP can file a Grievance expressing his/her dissatisfaction with any matter other than an Adverse Benefit Determination at any time.

8.209.5.B. The MCO, PIHP, or PAHP shall send the member written acknowledgement of each Grievance within two (2) working days of receipt.

8.209.5.C. The MCO, PIHP, or PAHP shall ensure that the individuals who make decisions on Grievances are individuals who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual, and who have the appropriate clinical expertise, as determined by the Department, in treating the member's condition or disease if deciding a Grievance that involves clinical issues.

8.209.5.D. The MCO, PIHP, or PAHP shall accept Grievances orally or in writing.

1. The MCO, PIHP, or PAHP shall dispose of each Grievance and provide notice as expeditiously as the member's health condition requires, not to exceed fifteen (15) working days from the day the MCO, PIHP, or PAHP receives the Grievance.

8.209.5.E. The MCO, PIHP, or PAHP may extend timeframes for the disposition of Grievances by up to fourteen (14) calendar days:

1. If the member requests the extension; or
2. The MCO, PIHP, or PAHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO, PIHP, or PAHP shall:

- a. Make reasonable efforts to give the member prompt oral notice of the delay.
- b. Give the member prior written notice of the reason for delay if the timeframe is extended and inform the Member of the right to file a grievance if the member disagrees with the decision.

8.209.5.F. The MCO, PIHP, or PAHP shall notify the member in writing of the disposition of a Grievance in the format established by the Department.

8.209.5.G. The written notice shall include the results of the disposition/resolution process and the date it was completed.

8.209.5.H. If the member is dissatisfied with the disposition of a Grievance provided by the MCO, PHIP, or PAHP, the member may bring the unresolved Grievance to the Department.

1. The Department will acknowledge receipt of the Grievance and dispose of the issue.
2. The disposition offered by the Department will be final.

8.209.6 OMBUDSMAN ASSISTANCE CONCERNING SERVICES FOR MEMBERS ENROLLED IN MCOS, PIHPS, and PAHPS

8.209.6.A. An Ombudsman under contract with the Department of Health Care Policy and Financing shall provide Ombudsman assistance concerning services for members enrolled in Medicaid MCOs, PIHPS, and PAHPs.

8.209.6.B. Upon request, the Ombudsman shall respond to and analyze a Grievance from a member enrolled in a Medicaid MCO, PIHP, or PAHP, or that member's Designated Client Representative, by:

1. Assisting the member or Designated Client Representative to articulate the Grievance, to understand the options available to resolve the Grievance and his/her rights and responsibilities, and to negotiate the appropriate Grievance process for his/her MCO, PIHP, or PAHP;
2. Acting as the member's Designated Client Representative if the member requests except that the Ombudsman shall not act as the Designated Client Representative in any State Fair Hearing as described at 10 CCR 2505-10, §8.057;
3. Facilitating problem resolution with the MCO, PIHP, or PAHP, or its network providers;
4. Referring members to other agencies as appropriate, including agencies that can directly assist members in a State Fair Hearing;
5. Conducting and reporting member satisfaction studies and/or quality assessment surveys authorized by the Department to measure member experience and satisfaction with Ombudsman staff and services;
6. Providing members with information on the exclusions and limitations that may be imposed on care, services, equipment and supplies under the Medicaid benefits structure;
7. Having a practical understanding of all applicable provisions of Title X, Article 16, C.R.S. and Medicaid Volume 8 rules; and

8. Avoiding any relationship or circumstance which creates or gives the appearance of a conflict of interest.

8.209.7 COMPLIANCE REQUIREMENTS FOR ALL MCOS, PIHPS, PAHPS AND THE OMBUDSMAN

- 8.209.7.A. MCOS, PIHPS, PAHPS, and the Ombudsman shall recognize and ensure members' rights to make and file Grievances and to Appeal Adverse Benefit Determinations through the Grievance and Appeal process for any reason.
- 8.209.7.B. For members with a disability, if the medical necessity of a requested procedure has not been established by the MCO, PIHP, or PAHP, the requesting physician must be consulted in person or by telephone before a final determination is made. If the requesting physician is not available, another network provider of the member/Designated Client Representative's choice shall be consulted. Such consultation shall be referenced in the notice. If the requesting physician is not available and the member/Designated Client Representative does not choose another network provider within two working days of the MCO's, PIHP's, or PAHP's request to make such a choice, the MCO, PIHP, or PAHP may proceed without consultation.
- 8.209.7.C. MCOS, PIHPS, PAHPS, and the Ombudsman shall develop written procedures for accepting, processing, and responding to all Grievances and Appeals from Medicaid members. For MCOS, PIHPS, and PAHPS, summaries of these procedures shall be disseminated to all participating providers and shall include summaries in the Member Handbook as described in Department contract requirements. The MCO, PIHP, or PAHP shall provide its complete Grievance and Appeal procedures to subcontractors and ensure subcontractor compliance with these rules and the MCO's, PIHP's, or PAHP's procedures. MCOS, PIHPS, PAHPS, and the Ombudsman shall obtain written approval from the Department for their internal Grievance and Appeals procedures.
- 8.209.7.D. MCOS, PIHPS, PAHPS, and the Ombudsman shall establish and maintain a timely and organized system(s) for recording, tracking, and resolving Medicaid members' Grievances and Appeals as specified in contract.
- 8.209.7.E. MCOS, PIHPS, PAHPS, and the Ombudsman shall confidentially maintain original records of all Grievances and Appeals from Medicaid members, including the original Grievance or Appeal, Adverse Benefit Determination, or resolution taken by the entity, and evidence of review activities. All such information shall be archived for ten (10) years from the date of the initial Grievance or Appeal.
- 8.209.7.F. MCOS, PIHPS, and PAHPS shall ensure that neither cultural, expressive, or receptive communication differences negatively impact the Grievance and Appeals process. MCOS, PIHPS, and PAHPS shall provide services to facilitate members' and Designated Client Representatives' effective use of the Grievance and Appeals process, inclusive of qualified interpreters for (1) persons with communication disabilities or differences and (2) non-English-speaking members. The MCO, PIHP, or PAHP shall consult with the member or the Designated Client Representative about the individual or medium that will assist, and such assistance shall be at the cost of the MCO, PIHP, or PAHP.
- 8.209.7.G. MCOS, PIHPS, and PAHPS shall provide the member, Designated Client Representative, or any other person, upon written release from the member or the member's legal guardian, access to or a copy of medical records, at no cost to the member, for dates of service occurring during enrollment in the MCO, PIHP, or PAHP. Such records shall be provided within a time frame that provides members copies of their records prior to any decision on a Grievance or Appeal, or in two weeks or less, if required by C.R.S. § § 25-1-801 and 25-1-802. The MCO, PIHP, or PAHP is only obligated to provide one copy of the member's medical records free of charge for each of the Medicaid member's Grievances or Appeals.

8.209.7.H. MCOs, PIHPs, and PAHPs shall monitor participating network subcontractors or providers to ensure compliance with all Grievance and Appeals rules and contract requirements.

8.209.7.I. MCOs, PIHPs, PAHPs, and the Ombudsman shall handle specific Medicaid member Grievance and Appeals information in the same way that medical record information is handled confidentially under State and Federal law and regulations.

8.209.7.J. Upon request by a member, the member's Designated Client Representative, or the member's provider, the MCO, PIHP, or PAHP shall disclose its standards for denial of treatments or other benefits on the grounds that such treatment or other covered benefit is not medically necessary, appropriate, effective, or efficient free of charge.

8.209.7.K. To assist members in making inquiries and filing Grievances and Appeals, MCOs, PIHPs, PAHPs, and the Ombudsman shall ensure that members and Designated Client Representatives can contact them during routine business hours through a toll-free telephone number.

8.212 COMMUNITY BEHAVIORAL HEALTH SERVICES

8.212.1 ENROLLMENT

8.212.1.A. The following individuals are not eligible for enrollment in the Community Behavioral Health Services program:

1. Qualified Medicare Beneficiary only (QMB-only).
2. Qualified Disabled and Working Individuals (QDWI)
3. Qualified Individuals 1 (QI 1).
4. Special Low Income Medicare Beneficiaries (SLMB).
5. Undocumented aliens, including non-qualified, undocumented and qualified aliens who have not met the five-year bar who are eligible for Federal Medicaid for care and services related to the treatment of an approved medical condition.
6. Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE).
7. Individuals who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan who are:
 - a. Found by a criminal court to be Not Guilty by Reason of Insanity (NGRI);
 - b. Found by a criminal court to be Incompetent to Proceed (ITP); or
 - c. Ordered by a criminal court to a State Institute for Mental Disease (IMD) for evaluation (e.g. Competency to proceed, sanity, conditional release revocation, pre-sentencing).
8. Individuals between ages 21 and 64 who receive inpatient treatment who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.

9. Individuals who are NGRI and who are in the community on Temporary Physical Removal (TPR) from the Colorado Mental Health Institute at Pueblo and who are eligible for Medicaid are exempted from the Community Behavioral Health Services program while they are on TPR. TPR individuals remain under the control and care of the Institute.
 10. Classes of individuals determined by the Department to require exclusion from the Community Behavioral Health Services program, defined as individuals residing in State Regional Centers for people with developmental disabilities and associated satellite residences for more than 90 days.
 11. Individuals who receive an individual exemption as set forth at Section 8.212.2.
 12. Individuals while determined presumptively eligible for Medicaid.
 13. Children or youth in the custody of the Colorado Department of Human Services -Division of Child Welfare or Division of Youth Corrections who are placed by those agencies in a Psychiatric Residential Treatment Facility (PRTF) as defined in C.R.S. 25.5-4-103, Residential Child Care Facilities (RCCF) or Qualified Residential Treatment Programs (QRTP), as defined in C.R.S. 26-6-102.
- 8.212.1.B. All other Medicaid clients shall be enrolled in the Community Behavioral Health Services program, and into a behavioral health organization in the client's geographic area.
1. The Department automatically re-enrolls a client into the same behavioral health organization if there is a loss of Medicaid eligibility of two months or less.

8.215 MEDICAID STATEWIDE MANAGED CARE SYSTEM CAPITATION RATE SETTING

8.215.1 DEFINITIONS

- 8.215.1.A. Actuary – Individuals who both meet the qualifications of the division of insurance, and who also are Members of the American Academy of Actuaries, and therefore are able to provide for actuarial certification of Medicaid rates in accordance with 42 CFR 438.6(c).

The Department incorporates by reference 42 CFR 438.6(c). No amendments or later additions of this regulation 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, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

- 8.215.1.B. Actuarially sound rates – For a defined population, a per member per month risk capitation amount that meets the requirements of 42 CFR 438.6(c) and is certified as actuarially sound by an actuary acting in his/her professional capacity.
- 8.215.1.C. Enrollee – A person who is eligible to receive services under a risk contract with the Department as a participant in the Medicaid Statewide Managed Care System.
- 8.215.1.D. Independent actuary – An actuary contracted by the Department who has not and will not contract with a Colorado Medicaid provider during the rate setting or rate effective periods and whose employer has not and will not provide actuarial services to a Managed Care Organization or Prepaid Inpatient Health Plan participating in the Medicaid Statewide Managed Care System during the rate setting or rate effective periods.

8.215.1.E. Managed Care Organization (MCO) shall mean an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR § 438.2 to operate as part of the State agency's Medicaid Statewide Managed Care System as defined in Section 8.205.

8.215.1.F. Medicaid Statewide Managed Care System means the program defined in Section 8.205.

8.215.1.G. Prepaid Inpatient Health Plan (PIHP) shall mean an entity that administers the State agency's statewide system of community behavioral health care as defined in Section 8.205.9 under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.215.2 LEGAL BASIS

The Medicaid Statewide Managed Care System is authorized by state law at 25.5-5, C.R.S. Part 4.

8.215.3 GENERAL PROVISIONS

8.215.3.A. The Department shall make prepaid capitation payments based on actuarially certified rates to MCOs and PIHPs based upon a scope of services defined in the MCOs and PIHPs contracts.

8.215.3.B. The Department shall contract with an independent actuary to prepare and certify actuarially sound rate ranges.

8.215.3.C. The Department's contracts with the MCOs and PIHPs shall contain rates within the actuarially certified rate ranges prepared by the independent actuary.

8.215.3.D. Rates calculations shall include estimates of future utilization of covered services that are:

1. Relevant to the expected or reasonable use of services by the MCOs and PIHP's enrollees, and
2. Based upon data that are of sufficient quality for rate setting.

8.215.3.E. To determine a reasonable cost of the service utilization described above in 8.215.3.D, the Department shall establish a price per unit of service. Such pricing:

1. Shall be consistent with the principles of actuarial soundness.
2. May be based upon the Medicaid fee-for-service payment for like services, provider costs, MCO or PIHP contracted rates, or other sources.

8.215.3.G. Data used to set rates shall be made available in summary form to any interested stakeholder.

8.215.3.H. The MCOs and PIHPs are required to maintain medical loss ratios of no less than 85% of total Medicaid capitations. Medical loss ratios of less than 85% shall result in a refund of premiums due to the Department in an amount such that the recalculated medical loss ratio, accounting for the premium change, meets the agreed upon threshold.

8.215.4 RATE SETTING TIMELINE

- 8.215.4.A. The Department shall publish a rate setting timeline when starting the process of establishing actuarially sound rate ranges.
- 8.215.4.B. The rate setting timeline shall provide explicitly for stakeholder feedback as part of the rate setting process.
- 8.215.4.C. The independent actuary shall consider stakeholder feedback in collaboration with the Department.
1. The decision to adopt the stakeholder feedback in the calculations of the actuarially sound rate ranges shall be at the discretion of the independent actuary.
 2. Notwithstanding the above, the independent actuary is encouraged to fully consider stakeholder feedback, in consultation with the Department, when the feedback provides for better quality or efficiency in the process of calculating actuarially sound rate ranges, and the feedback is consistent with principles of efficiency, economy and actuarial soundness.

8.215.5 CERTIFICATIONS

- 8.215.5.A. To the extent that the data used in rate setting come from the MCO or PIHPs, the MCO or PIHP shall provide a certification that the data supplied by the MCO or PIHP to the Department are accurate, truthful and represent costs and utilization solely for services covered under the MCO or PIHP contract for Medicaid eligible enrollees of that MCO or PIHP.
- 8.215.5.B. In accordance with 25.5-5-408 (e) and prior to entering into a contract with the Department, the MCO or PIHP shall certify that the rates set forth in the contract are sufficient to assure the financial stability of the MCO or PIHP.
- 8.215.5.C. In accordance with 25.5-5-408 (f)(I) and prior to entering into a contract with the Department, the MCO or PIHP shall retain an actuary to certify that the capitation rates set forth in the contract between the MCO or PIHP and the Department comply with all applicable federal and state requirements that govern said capitation payments. This certification must explicitly reference that the capitation rates conform to the federal requirement that rates be actuarially sound.

8.215.6 COST CONTAINMENT MECHANISMS

- 8.215.6.A. The Department shall establish cost-effective, capitated rates for the statewide system of community behavioral health care defined in Section 8.205.9 in a manner that includes cost containment mechanisms.
- 8.215.6.B. The cost containment mechanisms shall be consistent with the principles of actuarial soundness, as determined by the independent actuary.
- 8.215.6.C. These cost containment mechanisms shall include:
1. Limiting costs and data considered in rate setting to that reasonable based upon enrollees' need for services within the scope of services in the PIHPs' contracts.
 2. Establishing health status based risk adjusted case rates for a negotiated portion of the actuarially sound capitation rate. Case rates shall be calculated based upon a statewide average cost, providing PIHPs an incentive for efficiency relative to peers.

- 8.215.6.D. The Department may, upon consultation and feedback from the PIHPs and the stakeholder community, implement other cost containment mechanisms that it finds necessary to constrain rate growth to a level that is sustainable and appropriate.

8.220 COMPETITIVE PROCUREMENT AND SELECTIVE CONTRACTING, INCLUDING GLOBAL FEE PAYMENT PROGRAMS

This section of Staff Manual Volume 8 describes Medicaid competitive procurement and selective contracting.

8.221 GENERAL PROVISIONS

The Colorado Department of Health Care Policy and Financing (the State) may enter into contracts to provide a range of health care benefits identified in the State Plan to persons determined eligible for medical care under Title XIX of the Social Security Act (Medicaid). The Department under provisions of State and Federal law and regulation, and contingent upon Federal waiver(s), may elect to competitively procure and/or selectively contract for organ and other transplant services.

A. Transplant Services

1. The Department, after consultation with affected groups, may issue Requests for Proposals from providers to contract with the State for the provision of certain organ transplants and related services. A limited number of contracts may be executed with providers whose proposals demonstrate that they are qualified to provide adequate access to quality services, and whose price proposals are most advantageous to the State.
2. Effective on or after July 1, 1995 the Department may contract with selected providers under a global fee arrangement for transplant services related to heart, lung, liver, kidney, and bone marrow transplants. Under these contracts providers will receive a single payment for all services related to the transplant procedure, and a monthly case management fee as the Primary Care Physician for six months following the transplant. The following services are included under the global transplant payment:
 - a. Patient access to the transplant network
 - b. Provision of general assistance and education for the transplant patient and families or attendants
 - c. Transplant procedures
 - d. All services required by a transplant patient including organ acquisition, physician services, and certain non-hospital post-transplant care for a period not to exceed 6 months.
 - e. Related transportation for patients and necessary family member(s) or attendant(s)
3. The method of payment to be used for transplants under this program will be an inclusive rate per discharge.
4. All transplant services will be prior authorized as described in 8.317.
5. All transplant services will be subject to Quality Assurance review by the Peer Review Organization as described at 8.312.12., and as required under provisions of the Federal waiver and/or specific contract provisions of the competitively procured transplant program.

8.280 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

8.280.1 DEFINITIONS

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) means the child health component of Medicaid. The EPSDT program requires coverage of periodic and interperiodic screens, vision, dental and hearing care, diagnostic services needed to confirm the existence of a physical or mental illness or condition, and all medical assistance services that are recognized under Section 1905 of the Social Security Act, even if not offered under the state plan pursuant to federal laws applicable to the program (including 1905(a), 42 U.S.C. §§1396a(a)(42), 1396d(a)(4)(B) and 1396d(r)).

EPSDT Case Management means an activity that assists Medicaid clients in getting and/or coordinating services based on individual need.

EPSDT Outreach means methods to inform recipients or potential recipients, such as those found to be presumptively eligible, to enter into care.

EPSDT Outreach and Case Management Entity means an entity that has contracted with the Department to provide the activities specified in 8.280.3 below.

Personal Care Services means assistance with non-skilled activities of daily living in order to meet the client's physical, maintenance and supportive needs. This assistance may take the form of hands-on assistance (actually performing a task for the person), or prompting or cueing the client to complete the task.

8.280.2 EPSDT ELIGIBILITY

A child or youth age 20 and under enrolled in Medicaid are eligible for EPSDT services.

8.280.3 EPSDT OUTREACH AND CASE MANAGEMENT

8.280.3.A. EPSDT Outreach and Case Management entities shall provide pregnant women, children, their parents or legal guardians (based on the current eligibility information received from the Department) the following within 60 days of eligibility through oral communication including face to face meetings, discussions or telephone conversations, as well as written materials:

1. Information about EPSDT services and how to access them.
2. Education on the importance of preventive health care with an emphasis on well child exams, developmental and depression screenings, dental examinations, immunizations, and prenatal care.
3. Assistance in selecting a Primary Care Physician (PCP) or Managed Care Organization (MCO), and to supply a list of available options if requested. Children without a PCP shall be informed of the choices of PCPs and/or MCOs. Families/children shall notify the enrollment broker of their choice as described in 10 C.C.R. 2505-10, Section 8.205.
4. Assist clients in choosing an Accountable Care Organization if appropriate.
5. Assistance with coordinating primary health coverage with Medicaid benefits.
6. Assistance with coordinating appointments with providers, including assistance with missed appointments.

7. Assistance with reporting the birth of newborns to the local department of human/social services.
8. A current list of covered and uncovered services available in the community.
9. Information regarding the availability of non-emergency medical transportation.

8.280.4 EPSDT SERVICES

8.280.4.A. Periodic screening is a procedure used to determine a child's mental and physical growth progress, and to identify a disease or abnormality. Screening identifies additional diagnosis and treatments of physical or emotional problems.

1. Screening shall include a comprehensive health assessment performed soon after birth or as early as possible in a child's life and repeated at periodic intervals of time as recommended by the Colorado periodicity schedules.
2. The periodicity schedules describe the intervals at which preventive physical, sensory, developmental and behavioral screening, including vision; hearing and dental services shall be performed for enrolled children and youth age 20 and under. The periodicity schedules also include the recommended frequency of follow-up examinations.
3. The components of a screen shall include:
 - a. A comprehensive unclothed physical exam.
 - b. A detailed health and development history.
 - c. An assessment of vision, hearing, mouth, oral cavity and teeth, including referral to a dentist beginning at age 1, and other systems including but not limited to: Respiratory, Cardiovascular, Gastrointestinal, Genitourinary, Musculoskeletal, Skin, Neurologic, Psychiatric/Emotional/Education, and Nutrition.
 - d. A developmental screening including a range of activities to determine whether a child's emotional and developmental processes fall within a benchmarked range of achievement schedule according to the child's age group and cultural background. This screening shall include self-help and self-care skills, gross and fine motor development, communication skills or language development, social-emotional development, cognitive skills and appropriate mental/behavioral health screening.
 - e. Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines.
 - f. Lead Toxicity Screening - All children are considered at risk and should be screened for lead poisoning via blood testing. Children between the ages of 36 months and 72 months of age should receive a blood lead test if they have not been previously tested for lead poisoning.
 - g. Any appropriate age-specific screening or laboratory tests at intervals recommended by the Colorado Periodicity Schedule.
 - h. Health education and anticipatory guidance.

4. Screenings shall be age appropriate and performed in a culturally and linguistically sensitive manner by a provider qualified to furnish primary medical and/or mental health care services.
5. Results of screenings and examinations shall be recorded in the child's medical record. Documentation shall include at a minimum identified problems and negative findings and further diagnostic studies and/or treatments needed and date ordered.

8.280.4.B. Inter-Periodic exam

Inter-periodic exam shall be any health care that occurs outside the periodic preventive care screening such as a further diagnosis, evaluation, acute or sick care.

8.280.4.C. Diagnosis and treatment

1. When a screening examination indicates the need for further evaluation of the individual's health, diagnostic services are provided.
2. If the screening provider is not licensed or equipped to render the necessary treatment or further diagnosis, the screening provider shall refer the individual to an appropriate enrolled practitioner or facility, or to the EPSDT Outreach and Case Management Office for supportive help in locating an appropriate provider.
3. Treatment to correct or ameliorate defects, physical and mental illnesses or conditions discovered by the screening and diagnostic services shall be available.

8.280.4.D. Personal Care Services

Personal Care Services as defined in 8.280.1, are a benefit for clients age 20 and under who meet the criteria for EPSDT.

8.280.4.E Other EPSDT Benefits

1. All goods and services described in Section 1905(a) of the Social Security Act are a covered benefit under EPSDT when medically necessary as defined at 10 C.C.R. 2505-10, Section 8.076.1.8, regardless of whether such goods and services are covered under the Colorado Medicaid State Plan.
2. For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth at Section 8.076.1.8.b – g.

8.280.5 LIMITATIONS/SPECIAL CONSIDERATIONS

8.280.5.A. Experimental services or procedures are excluded.

8.280.5.B. Services or items not generally accepted as effective by the medical community are excluded.

8.280.5.C. Pharmaceutical items not requiring a prescription are excluded unless prior authorized and medically necessary.

8.280.5.D. Eyeglasses are a benefit only when ordered by an ophthalmologist or an optometrist. Vision benefits are limited to single or multi-focal clear plastic lenses and one standard frame.

8.280.5.E. Contact lenses or orthoptic vision treatment services shall be a benefit when medically necessary and shall require prior authorization submitted by an Ophthalmologist, Optometrist, or Optician.

8.280.5.F. Orthodontic services are available for children with congenital, severe developmental or acquired handicapping malocclusions when the orthodontist documents Medical Necessity that is confirmed by pre-treatment case review. Orthodontists shall submit requests for prior authorization of covered orthodontic services.

8.280.5.G. Early language intervention for children age birth through three with a hearing loss may be provided by audiologists, speech therapists, speech pathologists and Colorado Home Intervention Program (CHIP) providers

8.280.6 REFERRALS

When a client is enrolled a managed care plan, a referral from his/her primary care physician may be required for care provided by anyone other than the primary care physician. Any client may self-refer for routine vision, dental, hearing, mental health services or family planning services.

8.280.7 PRIOR AUTHORIZATIONS

Providers shall be responsible for obtaining prior authorization when required for identified services such as home health, orthodontia, private duty nursing and pharmaceuticals. Prior authorization of services is not a guarantee of payment.

8.280.8 MANAGED CARE AND CONTRACTED HEALTH CARE SERVICES

8.280.8.A The Contractor must ensure the delivery of EPSDT services for Contractor Covered Services. The Contractor must have written policies and procedures for providing EPSDT services including lead testing and immunizations to the eligible population.

8.280.8.B. The Contractor must comply with all EPSDT regulations set forth in 1905(a), 42 USC 1396d(r)(5) and 42 USC 1396d(a), and performance will be verified by paid claims.

8.280.8.C. The Contractor must assure the provision of all required components of periodic health screens.

8.280.8.D. At a minimum, such efforts shall include:

1. education and outreach to eligibles of the importance of EPSDT services;
2. a proactive approach to ensure eligibles obtain EPSDT services;
3. systematic communication process with network providers regarding the Department's EPSDT requirements;
4. process to measure and assure compliance with the EPSDT schedule; and,
5. a process to assure that the medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action; and,
6. comply with all reporting requirements and data needs for federal reporting.

8.280.9 REIMBURSEMENT

Reimbursement shall be in accordance with the regulations for pricing health services as reflected at 10 C.C.R. 2505-10, Section 8.200 for all EPSDT medical screening, diagnostic and treatment services

8.290 SCHOOL HEALTH SERVICES

8.290.1 DEFINITIONS

Administrative activities means service coordination, outreach, referral, enrollment and administrative functions that directly support the Medicaid program and are provided by qualified personnel or qualified health care professionals employed by or subcontracting with a participating district.

Board of Cooperative Education Services (BOCES) means a regional organization that is created when two or more school districts decide they have similar needs that can be met by a shared program. BOCES help school districts save money by providing opportunities to pool resources and share costs.

Care coordination plan means a document written by the district that describes how the district coordinates client services across multiple providers to assure effective and efficient access to service delivery and prevent duplication of services.

Case management services mean activities that assist the target population in gaining access to needed medical, social, educational and other services.

Disability means a physical or mental impairment that substantially limits one or more major life activities.

District means any BOCES established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado School for the Deaf and the Blind, created in article 80 of title 22, C.R.S., and any public school district organized under the laws of Colorado, except a junior college.

Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services as defined pursuant to 10 C.C.R. 2505-10, Section 8.280.1

Free Care Services (services provided to Medicaid enrolled students at no charge, and/or provided to the community at large free of charge) to be reimbursed where medical necessity has been established. This means Medicaid eligible services provided to enrolled students are available for reimbursement if all other Medicaid requirements are met.

Individualized Education Program (IEP) means a document developed pursuant to the federal Individuals with Disabilities Education Act (IDEA). The IEP guides the delivery of special education supports and services for the student with a disability.

Individualized Family Services Plan (IFSP) means a document developed pursuant to the IDEA. The IFSP guides the delivery of early intervention services provided to infants and toddlers (birth to age 3) who have disabilities, including developmental delays. The IFSP also includes family support services, nutrition services, and case management.

Local Services Plan (LSP) means a document written by the district that describes the types and the costs of services to be provided with the federal funds received as reimbursement for providing School Health Services.

Medicaid Administrative Claiming (MAC) means a method for a participating district to claim federal reimbursement for the cost of performing allowable administrative activities.

Medically at risk means a client who has a diagnosable physical or mental condition having a high probability of impairing cognitive, emotional, neurological, social, or physical development.

Medically necessary service means a benefit service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

Participating district means a district that is contracted with the Department of Health Care Policy and Financing (the Department) to provide and receive funding for School Health Services.

Qualified health care professional means an individual who is registered, certified or licensed by the Department of Regulatory Agencies (DORA) as a health care professional and who acts within the profession's scope of practice. In the absence of state regulations, a qualified health care professional means an individual who is registered or certified by the relevant national professional health organization.

Qualified personnel means an individual who meets Colorado Department of Education-recognized certification, licensing, registration, or other comparable requirements of the profession in which they practice.

School health service means medical or health-related assistance provided to a client, by qualified personnel or qualified health care professionals; which is required for the diagnosis, treatment, or care of a physical or mental disorder and is recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

Specialized transportation means transportation service necessary to provide a client with access to Medicaid services performed in the school or at another site in the community.

8.290.2 CLIENT ELIGIBILITY

8.290.2.A. Clients shall be eligible to receive services from participating districts if they are:

1. Enrolled in Medicaid,
2. Enrolled with a participating district;
3. Under the age of 21;
4. Have a disability or are medically at risk; and
5. Receive a referral for School Health Services according to an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), 504 Plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established.

8.290.3 PARTICIPATING DISTRICTS

8.290.3.A. Contracts may be executed with districts throughout Colorado that meet the following minimum criteria:

1. Approval of a Local Service Plan (LSP) by the Colorado Department of Education and the Department;

2. An assessment, documented in the LSP, of the health needs of students enrolled in the District; and
3. Evidence, documented in the LSP, of community input on the health services to be delivered to public school students.

8.290.3.B. The participating district may employ or subcontract with qualified personnel or qualified health care professionals to provide school health services or administrative activities.

8.290.4 SCHOOL HEALTH SERVICES, BENEFITS AND LIMITATIONS

8.290.4.A. School health services provided by participating districts to clients shall be medically necessary and prescribed under an IEP, IFSP or other medical plans of care.

8.290.4.B. School health services shall be provided in accordance with the client's individual need and shall not be subject to any arbitrary limitations as to scope, amount or duration.

8.290.4.C. School health services shall be delivered in the least restrictive environment consistent with the nature of the specific service(s) and the physical and mental condition of the client.

8.290.4.D. School health services shall not be for academic assessment.

8.290.4.E. Except for school health services delivered pursuant to the federal Individuals with Disabilities Education Act (IDEA), the Participating District shall not claim reimbursement for School Health Services to clients enrolled in managed care organizations that would normally be provided for clients by their managed care organization.

8.290.4.F. School health services may be performed in the school, at the client's home or at another site in the community by qualified personnel or a qualified health care professional. A qualified provider is defined as an individual who is registered, certified or licensed in accordance with and authorized to provide services by Colorado state law or federal regulations. In the absence of state regulations, a qualified provider must be registered or certified by the relevant national professional health organization and must be allowed to practice if the provider is qualified per Colorado state law. The following service categories are eligible for reimbursement in the School Health Services Program as further defined in the Department's School Health Services Program Manual.

1. Physician Services
2. Nursing Services
3. Personal Care Services
4. Psychological, Counseling and Social Work Services
5. Audiology Services
6. Speech, Language and Hearing Services
7. Occupational Therapy Services
8. Physical Therapy Services
9. Specialized Transportation Services

8.290.5 COORDINATION OF CARE

- 8.290.5.A. The participating district shall coordinate the provision of care with the client's primary health care provider for routine and preventive health care.
- 8.290.5.B. The participating district shall refer clients to their primary care provider, health maintenance organization or managed care provider for further diagnosis and treatment that may be identified as the result of EPSDT services.
- 8.290.5.C. When the client is receiving Medicaid services from other health care providers and the participating district, the participating district shall coordinate medical care with the providers to ensure that service goals are complementary and mutually beneficial to the client or shall show cause as to why coordination did not occur.
- 8.290.5.D. The participating district shall inform a family receiving case management services from more than one provider that the family may choose one lead case manager to facilitate coordination.

8.290.6 REIMBURSEMENT

- 8.290.6.A. The participating district shall obtain from the client or the client's guardian a written informed consent to submit Medicaid claims on behalf of the client.
- 8.290.6.B. The participating district shall abide by the Third Party Liability rule at 10 C.C.R. 2505-10, Section 8.061.2.23.
- 8.290.6.C. The participating district shall participate in a periodic time study based on instructions documented in the Department's School Health Services Program Manual, to determine the percentage of allowable time spent providing Medicaid-claimable school health services.
- 8.290.6.D. Claims Submission and Interim Payment
1. The participating district shall submit a procedure code specific fee-for-service claim for each school health service provided for each client.
 2. Interim payment for school health services provided shall be reimbursed on a monthly rate. The monthly rate shall be based on the participating districts actual, certified costs identified in the participating districts most recently filed annual cost report. For a new participating district, the monthly rate shall be calculated based on historical data.
 3. Interim payment shall be tied to claims submission by the participating district. Claims shall be monitored by the Department and if claim volume decreases significantly or drops to zero in any two consecutive months while school is in session, interim payment shall be withheld until the issue has been resolved.
 4. The participating district shall be notified of the monthly rate each state fiscal year no later than 30 days prior to July 1 of that state fiscal year.
 5. The participating district shall receive the federal share of the rate, not to exceed 100% of the federal match rate, as interim payment.
 6. School health services provided shall be billed as an encounter or in 15-minute unit increments, in accordance with proper billing practices as defined by the Health Insurance Portability and Accountability Act or by the Healthcare Common Procedure Coding System.

7. Specialized transportation services shall be billed as one-way trips to and from the destination.
8. Each participating district submitting claims for reimbursement shall follow proper billing instructions as outlined in the Department's School Health Services Program Manual and in accordance with 10 C.C.R. 2505-10, Section 8.040.2.
9. Each participating district shall submit claims for School Health Services program eligible services provided to eligible Medicaid recipients. To comply with the School Health Services program cost reconciliation requirements, all claims must be received by the fiscal agent within 120 days from the date of service. Claims submitted more than 120 days after the end of the state fiscal year (June 30th) will not be included in the cost reconciliation calculation and final payment as specified under Section 8.290.6.E.

8.290.6.E. Cost Reconciliation and Final Payment

1. Each participating district shall complete an annual cost report for school health services delivered during the previous state fiscal year covering July 1 through June 30. The cost report shall:
 - a. Document the participating district's total Medicaid allowable costs for delivering school health services, based on an approved cost allocation methodology; and
 - b. Reconcile the interim payments made to the participating district to the Medicaid allowable costs, based on an approved cost allocation methodology.
2. Each participating district shall complete an annual cost report for all school health services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due no later than 120 days after the close of the quarter ending June 30th as detailed in the Department's School Health Services Program Manual.
3. All annual cost reports shall be subject to an audit by the Department or its designee.
4. If a participating district's interim payments exceed the actual, certified costs of providing school health services, the participating district shall return an amount equal to the overpayment.
5. If a participating district's actual, certified cost of providing school health services exceeds the interim payments, the Department will pay the federal share of the difference to the Participating district.
6. Each participating district shall follow cost-reporting procedures detailed in the Department's School Health Services Program Manual.

8.290.6.F. Certification of Funds

1. The participating district shall complete a certification of funds statement, included in the cost report, certifying the participating district's actual, incurred costs and expenditures for providing school health services.

8.290.7 MEDICAID ADMINISTRATIVE CLAIMING, BENEFITS AND LIMITATIONS

- 8.290.7.A. Medicaid Administrative Claiming (MAC) services shall be performed in a school setting or at another site in the community.

8.290.7.B. MAC services include administrative activities and the activities listed in this Section 8.290.7.B. Additionally, MAC may include related paperwork, clerical functions or travel by employees or subcontractors which is solely related to and required to perform MAC services:

1. Medicaid Outreach
 - a. Medicaid outreach shall be activities that inform Medicaid eligible or potentially eligible individuals about Medicaid and how to access the program.
 - b. Medicaid outreach may only be conducted for populations served by the participating districts such as students and their parents or guardians.
2. Facilitating Medicaid Enrollment Determination
 - a. Facilitating Medicaid enrollment determination shall be activities that assist individuals in the Medicaid enrollment process.
 - b. Facilitating Medicaid enrollment determination may include making referrals for Medicaid enrollment determinations, explaining the enrollment process to prospective applicants, and providing assistance to individuals or families in completing or collecting documents for the Medicaid application.
3. Translation Related to Medicaid Services
 - a. Translation related to Medicaid services are translation services provided solely to assist individuals with access to Medicaid covered services, which services are not included in or paid for as part of a school health service. translation services may be provided by employees of, or subcontractors with participating districts.
 - b. Translation related to Medicaid services may include arranging for or providing oral or signing translation services that assist individuals with accessing and understanding necessary care or treatment covered by Medicaid or developing associated translation materials.
4. Medical Program Planning, Policy Development and Interagency Coordination
 - a. Medical program planning, policy development and interagency coordination shall be activities associated with the development of strategies to improve the coordination and delivery of Medicaid covered medical, dental or mental health services to school age children.
 - b. Medicaid program planning, policy development and interagency coordination may include performing collaborative activities with other agencies or providers.
5. Medical/Medicaid Related Training and Professional Development
 - a. Medical/Medicaid related training and professional development shall be activities for outreach staff of participating districts that include coordinating, conducting or participating in training events or seminars regarding the benefits of medical or Medicaid related services.
 - b. Medical/Medicaid related training and professional development may include how to assist individuals or families with accessing medical or Medicaid related services and how to effectively refer students for those services.

6. Referral, Coordination and Monitoring of Medicaid Services
 - a. Referral, coordination and monitoring of Medicaid services shall be activities that include making referrals for, coordinating or monitoring the delivery of Medicaid covered services. Activities that function as part of a school health service may not be included in this category.
7. Transportation Related to Medicaid Services
 - a. Transportation related to Medicaid services shall be activities when assisting an individual to obtain transportation to services covered by Medicaid (does not include the provision of the actual transportation service).

8.290.8 MEDICAID ADMINISTRATIVE CLAIMING REIMBURSEMENT

- 8.290.8.A. The participating district shall participate in a periodic CMS approved time study to determine the percentage of allowable time spent on providing Medicaid administrative activities.
- 8.290.8.B. The participating district shall complete a cost report for MAC for each time study quarter the district participated in based on a reporting schedule established by the Department.
 1. The cost report shall document the participating district's total Medicaid allowable costs for providing Medicaid administrative activities, based on a CMS approved cost allocation methodology.
 2. If a participating district's cost report for MAC is not submitted within the Department established reporting schedule the participating district shall not be able to seek reimbursement for the associated period.
 3. By July 30th of each fiscal year, the participating district shall receive a notification letter from the Department identifying the MAC cost reporting schedule.
- 8.290.8.C. Each participating district shall follow cost reporting procedures for MAC detailed in the Department's School Health Services Program Manual.
- 8.290.8.D. Payment
 1. Each participating districts cost report for MAC shall be developed into a claim by the Department and submitted to CMS for reimbursement if appropriate.
 2. Reimbursement to participating districts that have properly submitted valid claims for MAC shall be made on a quarterly basis.
- 8.290.8.E. Certification of Funds
 1. Each participating district shall complete a certification of funds statement, included in the cost report for MAC, certifying the participating district's actual, incurred costs and expenditures for providing Medicaid administrative activities.
 2. All cost reports and claims for MAC shall be subject to an audit by the Department or its designee.

8.295 School-Based Health Center Benefit Coverage Standard Incorporation by Reference

8.295.1 Standard Incorporated by Reference

All School-Based Health Centers shall be in compliance with the Colorado Medicaid School-Based Health Center Benefit Coverage Standard (approved August 1, 2012) incorporated by reference. The incorporation of the School-Based Health Center Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to §24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 03/04/2007, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 03/04/2007, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]