

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE – SECTION 8.000 Emergency Medical Transportation, Program Integrity

10 CCR 2505-10 8.000

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

8.001 ELECTRONIC VISIT VERIFICATION (EVV)

8.001.1 Definitions

- 8.001.1.A. Alternate Location means any location entered into the EVV Record that was not automatically collected as a part of the EVV record.
- 8.001.1.B. Colorado Medicaid ID means the Colorado Medicaid identification number assigned to each Medicaid member by the Department.
- 8.001.1.C. Department means the Colorado Department of Health Care Policy & Financing.
- 8.001.1.D. Direct Care Worker means the person providing a service to a client. The Direct Care Worker may be an employee of a Provider.
- 8.001.1.E. Direct Care Worker ID means the last five digits of the Direct Care Worker's social security number.
- 8.001.1.F. Edited EVV Entry means an EVV record that has had any element modified via Visit Modification as defined in Section 8.001.3.C.1.b.
- 8.001.1.G. Electronic Visit Verification (EVV) means the use of technology, including mobile device technology, telephony, or Manual Visit Entry, to verify the required data elements related to the delivery of a service mandated to be provided using EVV by the "21st Century Cures Act," P.L. No. 114-255, or this rule.
- 8.001.1.H. Electronic Visit Verification Record (EVV Record) means a record of a visit recorded by an EVV System containing all data points in Section 8.001.3.A.1.b. of this rule.
- 8.001.1.I. Electronic Visit Verification System (EVV System) means the State EVV Solution or a Provider Choice System used by a Provider to comply with the EVV requirements in this rule.
- 8.001.1.J. Exception means a data integrity alert identified by the State EVV Solution or Provider Choice System.
- 8.001.1.K. Geo-fencing means the practice of utilizing a virtual perimeter in a geographic area.
- 8.001.1.L. Live-in Caregiver means a caregiver who permanently or for an extended period of time resides in the same residence as the Medicaid member receiving services. Live-in Caregiver status is determined by meeting requirements established by the U.S. Department of Labor, Internal Revenue Service, or Department-approved extenuating circumstances. Documentation of Live-in Caregiver status must be collected and maintained by Provider or Financial Management Services Vendor.

- 8.001.1.M. Manual Visit Entry means an EVV recorded after the time of service delivery, including all data elements as defined in Section 8.001.3.A.1.b.
- 8.001.1.N. Mobile Visit Verification Application (MVV Application) means a mobile device application that is used by the Direct Care Worker to record visit data at the start and end of the visit.
- 8.001.1.O. Provider means an actively enrolled Medicaid provider in good standing as defined in Section 8.076.
- 8.001.1.P. Provider Choice System means an alternative to the State EVV Solution made available by the Department. A Provider Choice System is provided by a Provider and satisfies all requirements as defined in this rule, is compatible with the State EVV Solution, and is consistent with Federal and State law.
- 8.001.1.Q. Provider EVV Portal means the web-based administrative tool used by Providers using the State EVV Solution to manage EVV activity and add Manual Visit Entry data elements and to monitor all activity recorded in the EVV System for Provider Choice Systems.
- 8.001.1.R. Reason Codes means standard codes established by the Department used to explain a Manual Visit Entry, Visit Modification, or acknowledge an Exception for missing required visit information.
- 8.001.1.S. State EVV Solution means the portion of the EVV System that manages data related to the visit and includes the MVV Application, TVV System, and the Provider EVV Portal made available by the Department.
- 8.001.1.T. Telephonic Visit Verification System (TVV System) means a toll-free telephone number system used by Direct Care Workers to record visit data at the start and end of a visit.
- 8.001.1.U. Threshold means the Departmentally-defined acceptable limit, determined as a percent, of EVV data recorded after the time of service delivery through Visit Modification or Manual Visit Entry.
- 8.001.1.V. Visit Modification means the edit of required visit data elements, as defined in Section 8.001.3.A.1.b, after the time of service delivery.

8.001.2 Provider Applicability

- 8.001.2.A. Providers of the following services reimbursed by the Department as fee-for-service must utilize EVV:
1. Behavioral Services when provided in the home or community, as defined in Sections 8.212, and 8.500.94.B.2, when provided in the home or community;
 2. Consumer Directed Attendant Support Services as defined in Sections 8.510 and 8.500.90.I;
 3. Durable Medical Equipment when provided in the home or community as defined in Sections 8.595 and 8.590;
 4. Home Health Services as defined in Section 8.520.1.K;
 5. Homemaker Services as defined in Sections 8.490.1 and 8.500.94.B.8;
 6. Hospice Services when provided in the home as defined in Section 8.550.1;

7. Independent Living Skills Training as defined in Section 8.516.10.A.1;
8. In-Home Support Services as defined in Sections 8.506.4.C and 8.552.1.M;
9. Life Skills Training as defined in Section 8.553.1.H;
10. Pediatric Behavioral Therapies provided under Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Services, when provided in the home or community as defined in Section 8.280;
11. Pediatric Personal Care when provided in the home or community, as defined in Section 8.535.1;
12. Personal Care Services provided as defined in Sections 8.489.10.11 and 8.500.94.B.13;
 - a. Personal Care Services provided in a Provider-owned residential type setting and paid via per diem are excluded from the EVV requirements outlined in this rule.
13. Physical Therapy and Occupational Therapy when provided in the home or community as defined in Section 8.200.3.A.6;
14. Private Duty Nursing as defined in Section 8.540.1;
15. Respite when provided in the home or community, as defined in Sections 8.492.10.11 and 8.508.100.J;
16. Speech Therapy when provided in the home or community, as defined in Section 8.200.3.D.2; and
17. Youth Day Services when provided in the home or community as defined in Section 8.503.40.A.13.

8.001.3 Provider Responsibilities

8.001.3.A. The Department will make available the State EVV Solution to all Providers of services specified in Section 8.001.2.A. of this rule. The State EVV Solution will include an MVV Application, TVV System, and Provider EVV Portal.

1. The State EVV Solution made available by the Department must be used by all Providers except for Providers using a Provider Choice System pursuant to Section 8.001.3.B. of this rule. Providers using the State EVV Solution must do the following:
 - a. Utilize the MVV Application or the TVV System made available by the Department as the primary method for collecting visit data.
 - i. If the visit did not take place at the location captured by MVV or TVV, the Provider must indicate the actual visit location as an Alternate Location.
 - ii. If the MVV Application and TVV System are unavailable during an EVV visit, the Direct Care Worker and the Direct Care Worker's associated Provider, as applicable, are responsible for entering any uncaptured data elements for that visit via Manual Visit Entry. Manual Visit Entry must be used as the last alternative for recording the visit data.

- b. Collect, for each visit, the following data:
 - i. The Colorado Medicaid ID of the client receiving the service;
 - ii. Information to identify the Direct Care Worker providing the service;
 - iii. The time the visit begins and ends;
 - iv. The EVV-required service performed;
 - v. The date the visit occurs; and
 - vi. The location of the visit.

8.001.3.B. The Department will allow all Providers of services specified in Section 8.001.2.A. of this rule to utilize a Provider Choice System.

1. Providers using a Provider Choice System must utilize an EVV Provider Choice System that satisfies all technical specifications as identified by the Department to:
 - a. Collect and submit to the Department, for each visit, the data elements contained in Section 8.001.3.A.1.b. of this rule;
 - i. When a Provider enters visit data via Manual Visit Entry, the Provider Choice System must indicate that the data was entered manually.
 - ii. When a Provider modifies existing visit data, the Provider must indicate the reason code for modification and enter reason code notes, if pertinent or required.
 - b. Utilize a Direct Care Worker ID for all individuals providing services to clients, as identified in Section 8.001.1.E. of this rule;
 - c. Identify all Exceptions using standard codes identified by the Department;
 - d. Utilize the Reason Codes identified by the Department;
 - e. Resolve any Exceptions noted in the State EVV Solution; and
 - f. Submit data to the State EVV Solution in a format and at a frequency identified by the Department.
2. A Provider Choice System must maintain compliance with the requirements identified in this rule, including incorporating into the system any changes in data requirements that must be transmitted to the State EVV Solution. It is the responsibility of providers using a Provider Choice System to ensure successful interaction between their Provider Choice System and the State EVV Solution.
3. Any costs related to the development of a Provider Choice System will not be the responsibility of the Department.
4. The Department will not provide training or support on the interaction of individual Provider Choice Systems with the State EVV Solution.

5. If a Provider is unable to obtain a compatible Provider Choice System, the Provider must use the State EVV Solution made available by the Department.

8.001.3.C. Visit Entry and Visit Modifications

1. All visit data points as defined in Section 8.001.3.A.1.b. must be completed at time of service delivery.
 - a. If a visit is entered administratively, and not by a caregiver at the time of service, the visit is considered a Manual Visit Entry.
 - b. If any data elements are edited after the time of service delivery, the edits are considered to be a Visit Modification resulting in an Edited EVV Entry.
2. Manual Visit Entries and Edited EVV Entries are subject to Department audit based on published Department Thresholds, in accordance with Section 8.076.
3. Providers must maintain all documentation required to substantiate the data elements required by Section 8.001.3.A.1.b of this rule to support Manual Visit Entries, Visit Modifications, and Exceptions. If this documentation cannot be maintained in the EVV System utilized by the Provider, the documentation must be maintained outside of the EVV System. The documentation must be made available to the Department or the Department's designee upon request, as required by Section 8.130.2.
4. Providers must resolve any Exceptions associated with Manual Visit Entries and Visit Modifications.
5. Exemptions
 - a. Live-in Caregivers who have completed Department required documentation are not mandated to collect EVV data, unless otherwise required by their Provider as defined by 8.001.1.O. of this rule.
 - i. Falsification or misrepresentation of information on Live-in Caregiver documentation may result in Department revocation of an individual's Live-in Caregiver exemption. If Live-in Caregiver exemption is revoked, the caregiver and provider must complete EVV pursuant to this rule.
6. EVV Record Restrictions
 - a. The Department will not allow or accept biometric data, pictures, video, or voice recordings to identify clients or substantiate Medicaid visit data.
 - i. Visit data that includes biometric data, pictures, video, or voice recordings is not required and must not be submitted.
 - b. The Department will not allow or accept visit data that includes continual GPS tracking during a visit. The Department will only accept location information at the beginning and/or end of a Medicaid visit.
 - i. Visit data that includes continual GPS tracking is not required and must not be submitted.

- c. The Department will not utilize geo-fencing to restrict location of Medicaid service delivery.
 - i. Visit data that restricts location of service delivery using geo-fencing is not required and must not be submitted
- 8.001.3.D. Providers of the services specified in Section 8.001.2.A. of this rule must adhere to the following:
 - 1. Comply with all provisions of this rule.
 - 2. Use the State EVV Solution or a Provider Choice System to collect and maintain EVV data as required in Sections 8.001.3.A.1.b. and 8.001.3.B.1.a.
 - 3. Consistent with Section 8.130, maintain a record of clients subject to EVV requirements to whom they are providing services and the required data elements pertaining to these clients. The required data elements include:
 - a. Colorado Medicaid ID;
 - b. Last name;
 - c. First name;
 - d. One known address at which the client may routinely receive services; and
 - e. Telephone number.
 - 4. Maintain a current list of Direct Care Workers who are providing services subject to EVV requirements to clients enrolled in Colorado Medicaid and the required data elements pertaining to the Direct Care Workers. The required data elements include:
 - a. Last name;
 - b. First name; and
 - c. Direct Care Worker ID.
 - 5. Maintain all documentation certifying the status of Live-in Caregivers providing services otherwise subject to EVV requirements set forth in this rule. Evidence of valid Live-in Caregiver status must be available upon Department request.
 - 6. Utilize EVV for all services subject to the provisions of this rule.
 - 7. Report any known or suspected falsification of EVV data to the Department within two business days of discovery.
 - 8. Complete all required EVV training.
- 8.001.3.E. Compliance
 - 1. Providers are required to comply with the requirements of this rule beginning on August 3, 2020.

- a. Providers that fail to comply with this rule after August 3, 2020 may be subject to Compliance Monitoring and a Request for Written Response in accordance with Section 8.076.
 - b. Providers that fail to comply with this rule after October 1, 2020 may be subject to Compliance Monitoring, Request for Written Response, or Overpayment Recovery.
 - c. Providers that fail to comply with this rule after January 1, 2021 may be subject to Compliance Monitoring, Request for Written Response, Overpayment Recovery, Denial of Claims, Suspension, Termination, or Nonrenewal of their Colorado Medicaid Provider Agreement in accordance with Section 8.076.
2. If the Department determines that there is a credible allegation of fraud, the Provider may be subject to a Suspension of Payments in accordance with Section 8.076.4.

8.010 [Repealed 05/15/2014 per House Bill 14-1123]

8.011.1 GENERAL EXCLUSIONS FROM COVERAGE

The paragraphs which follow set forth the general exclusions from coverage of the Medical Assistance Program.

8.011.11 Excluded from coverage are items and services which generally enhance the personal comfort of the eligible person, but are not necessary in the diagnosis of, nor contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member; this exclusion does not apply to inoculations and immunizations provided.

.12 Also excluded are items and services for which neither the eligible person, nor any other person or organization, incurs a legal obligation to pay; an example of such an exclusion is the free chest X-rays provided by health organizations. In applying this particular exclusion, the determining factor is that there is a not legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations. A legal obligation to pay exists even when reimbursement is expected only to the extent of the patient's insurance coverage.

This exclusion, therefore does not prohibit program payment for such services rendered to the following persons:

- a. Indigents who because of their inability to pay are not charged by an institution which customarily charged for such services;
- b. Patients whose need for services resulted from the act or negligence of another who is or may be legally liable for the patient's medical expenses. The existence of a third party's liability does not affect the patient's obligation to pay for the services he received nor the ability of the Medical Assistance Program to provide such coverage in his behalf. (The additional consideration, however, is that such third-party liability and possible benefits must be sought, explored, and secured wherever possible);

- c. Individuals resident in homes for the aged when the agreement under which such residency is provided is inclusive of medical services and no payment is accepted from any person residing in the home regardless of their ability to pay. Payment could be made for services rendered by a source independent of such home or institution if that source customarily charges for such services. Thus, payment could be made for services furnished by a hospital or long-term care facility to which a resident of the home is sent (or for home health services by an agency), or for the services of a physician who is not an employee of such home. In addition, this sort of situation is true in certain types of nonprofit homes, certain homes operated by labor unions, and homes for members of religious orders, etc.
- .13 Also excluded as benefits are items and services paid for by a governmental entity, including federal programs such as the National Institutes of Health, the Veterans' Administration medical care program and other similar types of government sponsored medical care.
- .14 Neither can payment be made for services in hospitals which serve only a special category of the population, such as prisoners, nor for services furnished to prisoners in hospitals serving the general community.
- .15 Also excluded as a benefit are items and services which are not provided within the United States. This is inclusive of the 50 states of the Union, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.
- .16 Also, specifically excluded from coverage are items and services which are required as a result of war or of an act of war occurring after the effective date of the patient's current eligibility.
- .17 Also, specifically excluded from coverage under the Medical Assistance Program are injuries received by individuals who are engaged in riots, civil disobedience, or other acts specifically excluded by the congressional statute relating thereto.
- .18 Specific non-benefit items and services in each of the benefit categories are identified in that section of this manual relating to each category.
- .19 Payment for prenatal services delivered through "The Prenatal Care for Undocumented Women Pilot Program" shall not be made under any circumstances other than through a contracted Managed Care Organization as specified in 8.011.02, Section B.

8.012 PROVIDERS PROHIBITED FROM COLLECTING PAYMENT FROM RECIPIENTS

8.012.1 DEFINITIONS

8.012.1.A. Providers, for the purposes of this section 8.012, means any person, group or entity that renders services or provides items to a medical assistance recipient, regardless whether the person, group or entity is enrolled in the Colorado medical assistance program, excluding long-term care facilities licensed pursuant to Section 25-3-101, C.R.S. Section 25-3-101, C.R.S. is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

8.012.1.B. Claim for Penalty means the documented notification by a recipient or estate of a recipient that a Provider collected or attempted to collect payment from the recipient for medical assistance covered items or services.

8.012.2 PROVIDER LIABILITY

8.012.2.A. Providers are explicitly prohibited from collecting payment, or attempting to collect payment through a third party, from a recipient or the estate of the recipient for the cost or the cost remaining after payment by Medicaid, Medicare, or a private insurer of Medicaid covered items or services rendered to Medicaid recipients.

8.012.2.B. Providers shall be liable to a recipient or the estate of the recipient if the Provider knowingly receives or seeks collections through a third party of an amount in payment for Medicaid covered items or services.

8.012.2.C. Providers are prohibited from collecting, or attempting to collect, payment from recipients for Medicaid covered items or services regardless of whether Medicaid has actually reimbursed the Provider and regardless of whether the Provider is enrolled in the Colorado medical assistance program.

8.012.2.D. Providers shall be liable for the amount unlawfully received, statutory interest on the amount received from the date of receipt until the date of repayment, plus a civil monetary penalty equal to one half of the amount unlawfully received.

8.012.3 RECIPIENT CLAIMS

8.012.3.A. To establish a Claim for Penalty, a recipient or the estate of a recipient shall forward a written notice of Claim for Penalty to the Department and to the Provider within one hundred and twenty (120) calendar days from the date the Provider unlawfully received payment from the recipient. Department correspondence shall be sent to Program Integrity, 1570 Grant Street, Denver, CO 80203.

8.012.3.B. The Claim for Penalty shall establish Provider liability to the recipient or estate of the recipient for repayment of the amount unlawfully collected plus interest and a civil penalty equal to one-half the repayment

8.012.3.C. The notice of Claim for Penalty shall be a written document submitted by a recipient or estate of the recipient to the Department and the Provider describing (1) what Medicaid covered items or services were rendered, (2) how much money the Provider collected from the recipient or the estate of the recipient for those covered items or services and (3) dates of service the items or services were rendered.

8.012.3.D. The written notice of Claim for Penalty from the recipient or the estate of the recipient shall be legible and include detailed documents to substantiate the Claim for Penalty that payment was given to and unlawfully received by the Provider.

1. Detailed documents to substantiate the Claim for Penalty may include but are not limited to credit card receipts, cash receipts or documentation of processed checks.
2. The recipient or estate of the recipient is responsible for providing supporting documentation at the same time the notice of Claim for Penalty is sent to the Department.
3. Claim for Penalty sent to the Department must include written documentation showing that notice of the Claim for Penalty was sent to the Provider.
4. Documentation showing the Claim for Penalty was sent to the Provider may include but is not limited to copies of the certified mail signature card, post office return receipt, courier service confirmation of delivery, signature of receipt by the Provider or representative of the Provider's office or successful transmission report from a facsimile.

5. The Department may request additional information from the recipient or the estate of the recipient. It shall be the responsibility of the recipient or the estate of the recipient to satisfy the Department's requests for information within ten (10) calendar days from the date of request for the Claim for Penalty to be evaluated by the Department.
6. The Department shall review the Claim for Penalty and documents substantiating the Claim for Penalty submitted by the recipient or the estate of the recipient.
7. Any notice of Claim for Penalty that is not legible or is submitted without documents to substantiate that payment was made to and unlawfully received by the Provider shall be considered unfounded and shall be dismissed by the Department.

8.012.4 PROVIDER RESPONSE

8.012.4.A. Within ten (10) calendar days from the date of the recipient's written Claim for Penalty, the Provider named in the recipient's Claim for Penalty shall present the Department with either a signed written position statement with supporting documentation pertaining to the recipient's Claim for Penalty, or a signed written request for a telephone conference in which to be heard.

1. The written position statement with supporting documentation or the signed written request for a telephone conference shall be sent via certified mail, return receipt or FedEx/UPS so there is no dispute that Program Integrity, 1570 Grant Street, Denver, CO 80203 received them.

8.012.4.B. Provider requests for a telephone conference or signed written position statements received after ten (10) calendar days from the date of the recipient's or the estate of the recipient's Claim for Penalty, or failure to respond shall be considered a waiver of the Provider's right to be heard and the Claim for Penalty shall be found in the recipient's favor.

8.012.4.C. The Department shall determine whether the Claim for Penalty has been substantiated and shall send the recipient and the Provider named in the Claim for Penalty a written determination within thirty (30) calendar days from the date of the recipient's or the estate of the recipient's Claim for Penalty.

8.013 OUT-OF-STATE MEDICAL CARE

An eligible Colorado recipient, temporarily out of the state but still a resident of Colorado, is entitled to receive benefits to the same extent that Medicaid is furnished to residents in the state under any one of the following conditions:

- 1) Medical services are needed because of a medical emergency.

For these services no prior authorization is needed. Whether an emergent condition exists is determined by the provider rendering service. Documentation of the emergency must be submitted with the claim.

- 2) Medical services are needed because the recipient's health would be endangered if he/she were required to return to Colorado for medical care and treatment.

For these services no prior authorization is required. The determination as to whether the recipient's health would be endangered is made by the provider rendering service. Documentation of why the recipient's health would be endangered must be submitted with the claim. However, the medical consultant of the Colorado Medicaid Program must be notified prior to the provision of services under this paragraph.

- 3) The State Medicaid Director determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available in the state where the recipient is temporarily located.

Prior authorization from the Medicaid Program's medical consultant must be obtained for services provided under this paragraph.

- 4) It is the general practice for recipients in a particular locality to use medical resources in another state.

No prior authorization is necessary for services provided in accordance with this paragraph when the recipient of an area is obtaining services from a provider in a neighboring out of state locale. Prior authorization from the Medicaid Program's medical consultant is necessary if the recipient is receiving services from any other out of state provider not in a neighboring locale.

In addition, prior authorization from the Medicaid Program's medical consultant is required for all services which are only available out of state for Colorado Medicaid recipient's located in Colorado at the time services are necessary.

The above restrictions on out of state medical care shall not apply to children who reside out of the state for whom Colorado makes adoption assistance payments or foster care maintenance payments.

The county departments of social services shall advise all applicants and recipients of this policy.

8.013.1 ENROLLMENT PROCEDURES

To receive reimbursement, all out of state providers shall be required to enroll in the Colorado Medicaid Program. Out of state providers are subject to the same enrollment and screening rules, policies and procedures as in state providers, as specified in Section 8.125 Provider Screening..

8.013.2 REIMBURSEMENT PRINCIPLES

All claims except out of state nursing home claims must be submitted to the fiscal agent for the state with documentation showing that the above requirements have been met. (Out of state nursing home claims shall be paid in accordance with the Payment For Out Of State Nursing Home Care section of the Volume 8 staff manual.) All claims submitted to the fiscal agent must include:

- 1) A copy of the provider's current Medicaid provider agreement with its state (if applicable);
- 2) Its Colorado provider number; and
- 3) Complete address, including zip code.

In addition, providers must sign a provider agreement in order to receive reimbursement. The claim form and the information contained in it shall constitute provider agreement. Except as provided elsewhere in the Volume 8 staff manual, reimbursement for out of state care shall be as follows:

Reimbursement for inpatient hospital services shall be 90% of the Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services (DHHS).

Reimbursement for physician services shall be the lower of the following:

- A. HCFA Common Procedure Coding System (HCPCs) fee;

B. Provider's Actual Charge.

Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider's actual charge or a rate of reimbursement equal to the rate paid by Medicare.

Reimbursement for outpatient hospital services shall be 70% of billed charges.

The foregoing procedures shall be in effect for all out-of-state providers, except as provided for elsewhere in the staff manual Volume 8 regulations. Individual cases which are adversely affected by these procedures shall be presented to the Bureau of Medical Services, Director, Program Operations Division, Colorado Department of Social Services. Individual consideration shall be given to such cases.

The Department may negotiate a higher reimbursement rate for out-of-state hospital services that are prior authorized.

- A. These are cases which require procedures not available in Colorado and which must be prior authorized.
- B. The patient's physician may suggest where the patient should be sent, but the medical consultant for the Department is responsible for making the final determination based on the most cost effective institution consistent with quality of care.

8.014 NON-EMERGENT MEDICAL TRANSPORTATION

8.014.1. DEFINITIONS

8.014.1.A. Access means the ability to make use of.

8.014.1.B. Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.C. Ambulatory Vehicle means a passenger-carrying vehicle available for those clients able to walk and who do not rely on wheelchairs or other mobility devices, during boarding or transportation, which would necessitate a vehicle with a lift or other accommodations.

8.014.1.D. Ancillary Services mean services incurred indirectly when a client authorized to receive NEMT also requires the assistance of an Escort or financial assistance for meals or lodging.

8.014.1.E. At-Risk Adult means an adult who is unable to make personal or medical determinations, provide necessary self-care, or travel independently.

8.014.1.F. Child means a minor under the age of 18.

8.014.1.G. Day Treatment means facility-based services designed for Children with complex medical needs. Services include educational or day care services when the school or day care system is unable to provide skilled care in a school setting, or when the Child's medical needs put them at risk when around other Children.

8.014.1.H. Emergency Medical Transportation means Ground Ambulance or Air Ambulance transportation under Section 8.018 during which clients who are ill, injured, or otherwise mentally or physically incapacitated receive needed emergency medical services en route

8.014.1.I. Escort means a person who accompanies an At-Risk Adult or minor client.

- 8.014.1.J. Fixed-Wing Air Ambulance means a fixed wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.
- 8.014.1.K. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.
- 8.014.1.L. Medicaid Client Transport (MCT) Permit means a permit issued by the Colorado Department of Regulatory Agencies Public Utilities Commission (PUC) in accordance with the PUC statute at Section 40-10.1-302, C.R.S.
- 8.014.1.M. Mode means the method of transportation.
- 8.014.1.N. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment. Non-emergency care may be scheduled or unscheduled. This may include Urgent Care transportation and hospital discharge transportation.
- 8.014.1.O. Program of All Inclusive Care for the Elderly (PACE) is a capitated rate benefit which provides all-inclusive long-term care to certain individuals as defined in Section 8.497.
- 8.014.1.P. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.
- 8.014.1.Q. State Designated Entity (SDE) means the organization responsible for administering NEMT. For the purposes of this rule, the responsible SDE is determined by the client's county of residence.
- 8.014.1.R. Stretcher Van means a vehicle that can legally transport a client in a prone or supine position when the client does not require medical attention en route. This may be by stretcher, board, gurney, or another appropriate device.
- 8.014.1.S. Taxicab means a motor vehicle operating in Taxicab Service, as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.
- 8.014.1.T. Taxicab Service has the same meaning as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.
- 8.014.1.U. Trip means one-way transportation from the point of origin to the point of destination.
- 8.014.1.V. Urgent Care means an appointment for a covered medical service with verification from an attending physician or facility that the client must be seen or picked up from a discharged appointment within 48 hours.
- 8.014.1.W. Wheelchair Vehicle means a motor vehicle designed and used for the non-emergent transportation of individuals with disabilities who use a wheelchair. These vehicles include vans modified for wheelchair Access or wheelchair accessible minivans.

8.014.2. CLIENT ELIGIBILITY AND RESPONSIBILITIES

- 8.014.2.A. All Colorado Medical Assistance Program clients are eligible for NEMT services unless the client falls within the following eligibility groups on the date of the Trip:
1. Qualified Medicaid Beneficiary (QMB) Only
 2. Special Low Income Medicare Beneficiary (SLMB) Only

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3. Medicare Qualifying Individual-1 (QI-1) Only
 4. Old Age Pension- State Only (OAP-state only)
- 8.014.2.B. Child Health Plan Plus clients are not eligible for NEMT.
- 8.014.2.C. PACE clients receive transportation provided by their PACE organization and are not eligible for NEMT.
- 8.014.2.D. NEMT services may be denied if clients do not observe the following responsibilities:
1. Comply with applicable state, local, and federal laws during transport.
 2. Comply with the rules, procedures and policies of the SDE.
 3. Obtain authorization from their SDE.
 4. Clients must not engage in violent or illegal conduct while utilizing NEMT services.
 5. Clients must not pose a direct threat to the health or safety of themselves or others, including drivers.
 6. Clients must cancel their previously scheduled NEMT Trip if the ride is no longer needed, except in emergency situations or when the client is otherwise unable to cancel.
- 8.014.3. PROVIDER ELIGIBILITY AND RESPONSIBILITIES**
- 8.014.3.A. Providers must enroll with the Colorado Medical Assistance Program as an NEMT provider.
- 8.014.3.B. Enrolled NEMT providers must:
1. Meet all provider screening requirements in Section 8.125;
 2. Comply with commercial liability insurance requirements and, if applicable, PUC financial responsibility requirements established in the PUC statute at C.R.S. § 40-10.1-107;
 3. Refrain from attempting to solicit clients known to have already established NEMT service with another provider;
 4. Maintain and comply with the following appropriate licensure, or exemption from licensure, requirements:
 - a. PUC common carrier certificate as a Taxicab;
 - b. PUC MCT Permit as required by the PUC statute at C.R.S. § 40-10.1-302;
 - c. Ground Ambulance license as required by Department of Public Health and Environment (CDPHE) rule at 6 CCR 1015-3, Chapter Four;
 - d. Air Ambulance license as required by CDPHE rule at 6 CCR 1015-3, Chapter Five; or
 - e. Exemption from licensure requirements in accordance with PUC statute at C.R.S. § 40-10.1-105.
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5. Only provide NEMT services appropriate to their current licensure(s) and within the geographic limitations applicable to the licensure; and
6. Ensure that all vehicles and auxiliary equipment used to transport clients meet federal, state, and local safety inspection and maintenance requirements.

PUC statute at C.R.S. §§ 40-10.1-105, 40-10.1-107 and 40-10.1-302 (2019) and CDPHE rule at 6 CCR 1015-3, Chapters Four and Five (2019), are hereby incorporated by reference.

8.014.3.C. NEMT transportation providers must maintain a Trip report for each NEMT Trip provided and must, at a minimum, include:

1. The pick-up address;
2. The destination address;
3. Date and time of the Trip;
4. Client's name or identifier;
5. Confirmation that the driver verified the client's identity;
6. Confirmation by the client, Escort, or medical facility that the Trip occurred;
7. The actual pick-up and drop off time;
8. The driver's name; and
9. Identification of the vehicle in which the Trip was provided.

8.014.3.D. Multiple Loading

1. NEMT providers may not transport more than one client at the same time, unless the additional passenger is an Escort.
2. NEMT providers may transport more than one client at the same time if the trip occurs in a bus. Each client must agree to be transported with other clients and clients must sit at least six feet apart.

8.014.3.E. The Section 8.014.3 requirements do not apply to client reimbursement or bus or rail systems.

8.014.4. COVERED PLACES OF SERVICE

8.014.4.A. NEMT must be provided to the closest provider available qualified to provide the service the client is traveling to receive. Exceptions may be made by the SDE in the following circumstances:

1. If the closest provider is not willing to accept the client, the client may use NEMT to access the next closest qualified provider.
2. If the client has complex medical conditions that restrict the closest medical provider from accepting the patient, the SDE may authorize NEMT to be used to travel to the next closest qualified provider. The treating medical provider must send the SDE written documentation indicating why the client cannot be treated by the closest provider.

3. If a client has moved within the three (3) months preceding an NEMT transport, the client may use NEMT to their established medical provider seen in their previous locale. During these three (3) months, the client and medical provider must transfer care to the closest provider as defined at Section 8.014.4.B. or determine transportation options other than NEMT.

8.014.5. COVERED SERVICES

8.014.5.A. Transportation Modes

1. Covered Modes of transportation include:
 - a. Bus and public rail systems
 - i. Transit passes may be issued by the SDE when the cumulative cost of bus tickets exceeds the cost of a pass.
 - b. Personal vehicle mileage reimbursement
 - c. Ambulatory Vehicles
 - d. Wheelchair Vehicles
 - e. Taxicab Service
 - f. Stretcher Van
 - g. Ground Ambulance
 - h. Air Ambulance
 - i. Commercial plane
 - j. Train

8.014.5.B. NEMT Services

1. NEMT is a covered service when:
 - a. The client does not have Access to other means of transportation, including free transportation;
 - b. Transportation is required to obtain a non-emergency service(s) that is medically necessary, as defined in Section 8.076.1.8.; and
 - c. The client is receiving a service covered by the Colorado Medical Assistance Program.
2. NEMT services may be covered for clients even if the medical procedure is paid for by an entity other than the Colorado Medical Assistance Program.
3. Non-emergent ambulance service (Ground and Air Ambulance), from the client's pickup point to the treating facility, is covered when:
 - a. Transportation by any other means would endanger the client's life; or

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- b. The client requires basic life support (BLS) or advanced life support (ALS) to maintain life and to be transported safely.
 - i. BLS includes:
 - 1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;
 - 2. Suctioning en route (not deep suctioning); and
 - 3. Airway control/positioning.
 - ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference.
 - 1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.
 - 2. ALS Level 2 includes:
 - a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or
 - b. The provision of at least one of the following ALS procedures:
 - i. Manual defibrillation/cardioversion.
 - ii. Endotracheal intubation.
 - iii. Central venous line.
 - iv. Cardiac pacing.
 - v. Chest decompression.
 - vi. Surgical airway.
 - vii. Intraosseous line.
- 4. NEMT may be provided to an Urgent Care appointment under the following circumstances:
 - a. A provider is available;
 - b. The appointment is for a covered medical service with verification from an attending physician that the client must be seen within 48 hours; and
 - c. The client is transported to an Urgent Care facility, which may include a trauma center if it is the nearest and most appropriate facility.

8.014.5.C. Personal Vehicle Mileage Reimbursement

1. Personal vehicle mileage reimbursement is covered for a privately owned, non-commercial vehicle when used to provide NEMT services in accordance with Section 8.014.5.B and owned by:
 - a. A client, a client's relative, or an acquaintance; or
 - b. A volunteer or organization with no vested interest in the client.
2. Personal vehicle mileage reimbursement will only be made for the shortest Trip length in miles as determined by an internet-based map, Trip planner, or other Global Positioning System (GPS).
 - a. Exceptions can be made by the SDE if the shortest distance is impassable due to:
 - i. Severe weather;
 - ii. Road closure; or
 - iii. Other unforeseen circumstances outside of the client's control that severely limit using the shortest route.
 - b. If an exception is made under Section 8.014.5.C.2.a., the SDE must document the reason and pay mileage for the actual route traveled.
3. To be reimbursed for personal vehicle mileage, the client must provide the following information to the SDE within forty-five (45) calendar days of the final leg of the Trip:
 - a. Name and address of vehicle owner and driver (if different from owner);
 - b. Name of the insurance company and policy number for the vehicle; and
 - c. Driver's license number and expiration date.

8.014.5.D. Ancillary Services

1. Escort
 - a. The Colorado Medical Assistance Program may cover the cost of transporting one Escort when the client is:
 - i. A Child.
 1. An Escort is required to accompany a client if the client is under thirteen (13) years old, unless the Child:
 - a. Is traveling to a Day Treatment program (Children are not eligible for NEMT travel to and from school-funded day treatment programs);
 - b. The parent or guardian signs a written release;

- c. Reimbursement will only be made for meals and lodging for which clients and Escorts are actually charged, up to the per diem rate established by the Colorado Medical Assistance Program.
- d. Meals and lodging will not be paid or reimbursed when those services are included as part of an inpatient stay.

8.014.6. NON-COVERED NEMT SERVICES AND GENERAL LIMITATIONS

8.014.6.A. The following services are not covered or reimbursable to NEMT providers as part of a NEMT service:

- 1. Services provided only as a convenience to the client.
- 2. Charges incurred while client is not in the vehicle, except for lodging and meals in accordance with Section 8.014.5.D.2.
- 3. Transportation to or from non-covered medical services, including services that do not qualify due to coverage limitations..
- 4. Waiting time.
- 5. Cancellations.
- 6. Transportation which is covered by another entity.
- 7. Metered taxi services.
- 8. Charges for additional passengers, including siblings or Children, not receiving a medical service, except when acting as an Escort under Section 8.014.5.D.1.
- 9. Transportation for nursing facility or group home residents to medical or rehabilitative services required in the facility's program, unless the facility does not have an available vehicle.
- 10. Transportation to emergency departments to receive emergency services. See Section 8.018 for Emergency Medical Transportation services.
- 11. Providing Escorts or the Escort's wages.
- 12. Trips to receive Home and Community Based Services
 - a. Non-medical transportation should be utilized if other transportation options are not available to the client.

8.014.6.B. General Limitations

- 1. The SDE is responsible for ensuring that the client utilizes the least costly Mode of transportation available that is suitable to the client's condition.

8.014.7. AUTHORIZATION

8.014.7.A. All NEMT services must be authorized as required by the SDE.

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1. Authorization requests submitted more than three months after an NEMT service is rendered will be denied.
 2. NEMT services may be denied if proper documentation is not provided to the SDE.
- 8.014.7.B. If a client requests transportation via Wheelchair Vehicle, Stretcher Van, or ambulance, the SDE must verify the service is medically necessary with the client's medical provider
1. Medical or safety requirements must be the basis for transporting a client in the prone or supine position.
- 8.014.7.C. Out-of-State NEMT
1. NEMT to receive out of state treatment is permissible only if treatment is not available in the state of Colorado.
 2. The following border towns are not considered out of state for the purposes of NEMT prior authorization:
 - a. Arizona: Flagstaff and Teec Nos Pos.
 - b. Kansas: Elkhart, Goodland, Johnson, Sharon Springs, St. Francis, Syracuse, Tribune.
 - c. Nebraska: Benkelman, Cambridge, Chappell, Grant, Imperial, Kimball, Ogallala, and Sidney.
 - d. New Mexico: Aztec, Chama, Farmington, Raton, and Shiprock.
 - e. Oklahoma: Boise City.
 - f. Utah: Monticello and Vernal.
 - g. Wyoming: Cheyenne and Laramie.
- 8.014.7.D. Prior Authorization
1. The following services require prior authorization by Colorado Medical Assistance Program:
 - a. Out-of-state travel, except to the border towns identified at section 8.014.7.C.2.
 - b. Air travel, both commercial air and Air Ambulance.
 - c. Train travel via commercial railway.
 - d. Second Escort.
 2. Prior authorization requests require the following information:
 - a. NEMT prior authorization request form completed by SDE and member's physician and submitted to Colorado Medical Assistance Program according to form instructions.

- i. The Colorado Medical Assistance Program will return requests completed by non-physicians and incomplete requests to the SDE.
- ii. The Colorado Medical Assistance Program's determination will be communicated to the SDE. If additional information is requested, the SDE must obtain the information and submit to the Colorado Medical Assistance Program. If the request is denied, the SDE must send the client a denial notice.

8.014.8. INCORPORATIONS BY REFERENCE

The incorporation by reference of materials throughout section 8.014 excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), 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.

8.015 ELECTRONIC HEALTH RECORD INCENTIVE PAYMENT PROGRAM

8.015.1 INCORPORATION BY REFERENCE

Title 42 of the Code of Federal Regulations, Part 495 (2010) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203

8.015.2 DEFINITIONS

Pediatrician means a medical doctor who holds a board certification in Pediatrics from the American Board of Pediatrics or provides greater than 50% of services to patients who are 18 years of age or younger.

8.015.3 ELIGIBLE PROVIDERS

8.015.3.A. To qualify for incentive payments, a provider must be an eligible professional or eligible hospital as specified in 42 CFR §495.4 and 42 CFR §495.304, and must have an active Colorado Medicaid provider identification number that has been assigned and is maintained by the Department.

8.015.3.B. An eligible professional participating in the Medicare electronic health record incentive program is not eligible to receive the Medicaid incentive payment through the Colorado Medicaid Electronic Health Record Incentive Payment Program in the same participation year.

8.015.4 ACTIVITIES REQUIRED TO RECEIVE THE INCENTIVE PAYMENT

8.015.4.A. Eligible professionals and eligible hospitals must register with the Department in order to be eligible to participate in the incentive program.

8.015.4.B. An eligible professional or eligible hospital in the first participation year under the Colorado Electronic Health Record Incentive Payment Program must attest to adopting, implementing or upgrading electronic health record technology that has been certified by the Office of the National Coordinator for Health Information Technology, as defined in 42 CFR §495.302, in order to be eligible to receive payment for the first year of participation.

8.015.4.C. Eligible professionals in their second through sixth participation years and eligible hospitals in their second and third participation years must attest to meaningful use of certified Electronic Health Record technology for each year of participation in order to be eligible to receive payment for that year.

1. For eligible professionals, attestation to meaningful use means that the eligible professional meets the meaningful use criteria set forth in 42 CFR §495.6(a), (c) and (d).
2. For eligible hospitals, attestation to meaningful use means that the eligible hospital meets the meaningful use criteria set forth in 42 CFR §495.6(b), (c) and (e).

8.015.4.D. Eligible professionals and eligible hospitals must submit all statements of attestation and retain documentation to support attestations.

8.015.5 ESTABLISHING MEDICAID PATIENT VOLUME

8.015.5.A. Eligible professionals and eligible hospitals must establish and demonstrate the Medicaid patient volume necessary for participation in the Colorado Medicaid Electronic Health Record Incentive Payment Program, using the patient volume methodologies defined in 42 CFR §495.306(c) or (d). Eligible professionals and eligible hospitals must attest to meeting Medicaid patient volume requirements and demonstrate evidence of attested patient volume upon the request of the Department.

8.015.6 INCENTIVE PAYMENTS

8.015.6.A. Payments to eligible professionals are calculated in the manner defined in 42 CFR §495.310 once for each year of eligibility after the eligible professional has submitted the required attestation. Payments are disbursed one time per year of eligibility.

8.015.6.B. Payments to eligible hospitals are calculated one time only, when the eligible hospital registers to participate in the Incentive Program and makes the appropriate attestation. Payments are calculated in the manner defined in 42 CFR §495.310. These payments are disbursed one time per year of eligibility over a three-year period.

8.015.7 SUSPENSION, EXCLUSION AND OFFSET OF PAYMENTS

8.015.7.A. The Department may suspend payment of incentive payments to an eligible provider under any of the following conditions:

1. The provider fails to timely and completely comply with the audit obligations contained in the Audit section of these rules;
2. The provider is under an active audit at the time of payment;
3. The provider has a deficiency finding resulting from an audit or review and is required, at the time of payment, by the Department or duly authorized agent of the Department, to initiate or to complete a Corrective Action Plan;
4. There is a credible allegation that the provider has falsified documents or made false or misleading attestations;
5. There is a credible allegation of fraud related to the provider's participation in the medical assistance program;

6. There is a credible allegation that the provider has retaliated against an employee for whistle blowing about a provider's non-compliance with program requirements or about a provider's false attestations;
 7. The provider is on the federal Office of Inspector General exclusion list at the time of payment;
 8. The provider is indicted for, or found guilty of, an action in any state or federal court that could qualify for exclusion on the federal Office of Inspector General exclusion list;
 9. The provider has been served and is subject to any civil or false claims action seeking the return of medical assistance benefits or another incentive payment;
 10. The provider's medical assistance benefits are suspended;
 11. The provider owes the Department a refund of medical assistance benefits, or is subject to offset or collection activities;
 12. The federal government requests a suspension;
 13. The provider has been terminated for cause from Colorado's medical assistance program, the medical assistance program of another State, or from Medicare; or
 14. The Department determines that suspension is in the best interests of the public.
- 8.015.7.B. An eligible provider may be excluded from participation in the program under any of the following conditions:
1. The provider repeatedly fails to comply with the audit obligations contained in the Audits section of these rules;
 2. There a judicial finding that the provider has falsified documents or made false or misleading attestations;
 3. The provider is listed on the federal Office of Inspector General exclusion list;
 4. The federal government requests exclusion;
 5. The provider has failed to satisfactorily or timely complete a Corrective Action Plan; or
 6. The provider has been terminated for cause from participation in Colorado's medical assistance program, the medical assistance program of another State, or from participation in Medicare.
- 8.015.7.C. The Department may recoup by offset any incentive payments that did not meet program requirements from other incentive payments due to the eligible provider, from medical services benefits payments due to the eligible provider or from medical services benefits due to another Medicaid provider who is billing for the eligible provider's services.
- 8.015.7.D. The Department may recoup by offset any improper or overpaid medical services benefits paid to or on behalf of an eligible provider from any incentive payment to that eligible provider under this program.

8.015.8 AUDITS

8.015.8.A. Eligible providers shall maintain all program-related records including documentation to support attestations and use and expenditures for seven years for audit purposes

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

1. 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.
2. 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.

8.015.8.C. 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, Corrective Action Plans and attestations. Upon request, and at the provider's expense, providers shall make available all necessary and complete records for audit purposes and shall deliver copies of purchase receipts and other documentation to the Department or any other duly authorized agent as specified in the request.

8.015.8.D. Upon request, eligible providers shall demonstrate to the State, the federal government, the Medicaid Fraud Control Unit and any other duly authorized agent of a governmental agency, that the provider can perform those actions and activities:

1. to which the provider has attested, or
2. which are required by a Corrective Action Plan.

8.015.9 CORRECTIVE ACTION PLANS

8.015.9.A. An eligible provider who fails to conform to program requirements or for whom deficiencies have been identified may be required to initiate and complete a Corrective Action Plan, as approved by the Department or its duly authorized agent. The purpose of the Corrective Action Plan is to assure that the eligible provider comes into conformity with program requirements and corrects deficiencies, at the provider's sole expense.

8.015.9.B. The Corrective Action Plan shall be provided to the auditor at the completion of the audit or within two weeks of a when requested by the Department or its duly authorized agent, unless an extension is granted. The plan shall identify:

1. The actions or corrective measures that the Provider will take to correct the identified deficiencies, to bring the providers operations into compliance with program requirements, or will take to achieve recommended improvements;
2. The name of the contact person responsible for corrective action; and
3. The anticipated completion date.

8.015.10 APPEALS

8.015.10.A. A provider may request informal reconsideration of any of the following Electronic Health Records Incentive Payment Program decisions that the provider disputes:

1. Eligibility determinations. A provider excluded from participation in the program may challenge that denial by mailing, or hand delivering, to the Department a written request for an informal reconsideration of the denial within 30 days of its issuance. A copy of the denial, if written, must be enclosed with the request.
2. Incentive payments, including payment amounts.
 - a. An eligible provider dissatisfied with a decision to deny the eligible provider all or part of an incentive payment, or dissatisfied with the amount of an incentive payment, may challenge that decision by mailing, or hand delivering, to the Department a written request for informal reconsideration of the decision within 30 days of the issue date of the decision. A copy of the decision must be enclosed with the request for informal reconsideration with an explanation of the basis for the appeal.
 - b. An eligible provider dissatisfied with a decision to suspend payment of an incentive payment or to an offset of incentive payments, may challenge those actions by mailing, or hand delivering, to the Department a written request to review the action taken within 30 days of the action.
3. Demonstration of adopting, implementing, and upgrading technology, or demonstration of meaningful use. An eligible provider dissatisfied with findings regarding attestations for adopting, implementing or upgrading technology, or meaningful use of technology, may appeal the audit by mailing, or hand delivering, to the Department a written request to review the audit results within 30 days of the action.
4. Audit results. An eligible provider dissatisfied with the results of an audit may appeal the audit by mailing, or hand delivering, to the Department a written request to review the audit results within 30 days of the action.
5. Corrective action plan. An eligible provider dissatisfied with issues related to a Corrective Action Plan, may appeal by mailing, or hand delivering, to the Department a written request to review the Corrective Action Plan within 30 days of the action.

8.015.10.B. A provider dissatisfied with the Department's informal reconsideration decision may submit a written appeal of the decision by mailing, or hand delivering, to the Department a written request to review the informal reconsideration decision within 30 days of the date of the decision. This result of this review is the final agency decision.

8.015.10.C. All written requests for informal reconsideration or appeal of the informal reconsideration decision must be mailed to:

Department of Health Care Policy and Financing, ATTN: Internal Audit Section, 1570 Grant St,
Denver, CO 80203.

8.015.10.D. A provider dissatisfied with a Department's final agency decision may appeal that decision according to the procedures set forth in 10 CCR 2505-10 Section 8.050, 3, PROVIDER APPEALS.

8.016 ALTERNATIVE BENEFIT PLAN

8.016.A Pursuant to § 1937 of the Social Security Act, effective January 1, 2014, all Medicaid clients in the following eligibility categories shall receive the Alternative Benefit Plan:

1. adults whose total household income does not exceed 133% of the federal poverty level and
2. parents and caretaker relatives whose total household income is between 69% and 133% of the federal poverty level.

8.016.B The Alternative Benefit Plan includes the services offered in Colorado Medicaid's Approved State Plan and Habilitative Services.

8.017 HABILITATIVE SERVICES

8.017.A DEFINITION

Habilitative services means services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in the Alternative Benefit Plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.

8.017.B COVERED SERVICES

Habilitative therapy services shall have parity in amount, scope, and duration to rehabilitative therapies and will only consist of physical, occupational, and speech-language pathology services.

8.017.C ELIGIBLE CLIENTS

Habilitative services shall only be available to the eligibility categories described in § 8.016.A.

8.017.D ELIGIBLE PROVIDERS

8.017.D.1 Habilitative Physical Therapy services shall only be provided by a licensed physical therapist who is an approved Medicaid provider or a physical therapist assistant under the general supervision of a licensed physical therapist who is an approved Medicaid provider.

8.017.D.2 Habilitative Occupational Therapy services shall be provided by a licensed occupational therapist who is an approved Medicaid provider or an occupational therapy assistant under the general supervision of a licensed occupational therapist.

8.017.D.3 Habilitative Speech Language Pathology services shall be provided by any of the following:

- a. A certified speech language pathologist with a current certification issued by the Department of Regulatory Affairs;
- b. A clinical fellow under the general supervision of an American Speech-Language-Hearing Association (ASHA) certified speech language pathologist; or
- c. A speech language pathology assistant with an associate degree from a program in which the individual received technical training in the scope of work recommended by ASHA for speech language pathology assistants.

8.017.E PRIOR AUTHORIZATION OF SERVICES

A medical prescription is required for covered services. The provider shall be responsible for submitting a prior authorization request that includes the medical prescription to the Department's designee for all covered services in 8.017.B. Following the receipt of a complete request, the Department's designee shall approve or deny all requests for prior authorization and shall determine the length of time that the service is medically necessary. A prior authorization request shall be effective for a length of time not to exceed 12 months.

8.017.F LIMITATIONS

8.017.F.1. Clients accessing Habilitative Physical or Habilitative Occupational Therapy are limited to 5 units per date of service and 48 units per state fiscal year (July 1 to June 30). A unit is defined by the current procedural terminology (CPT) code.

8.017.F.2 For Habilitative Speech Language Pathology:

- a. Services are limited to 5 units per date of service. A unit is defined by the current procedural terminology (CPT) code.
- b. Diagnostic procedures provided by an audiologist for the purpose of determining general hearing levels or for the distribution of a hearing device are not a covered benefit except for individuals eligible for the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT).

8.017.F.3 All services described in § 8.017.B Covered Services shall be provided in accordance with 42 CFR § 440.110 (2000) which is hereby incorporated by reference. The incorporation by reference of this regulation excludes later amendments to, or editions of, the reference material. The regulation is available from the U.S. Government Printing Office at <http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol4/pdf/CFR-2010-title42-vol4-sec440-110.pdf>. 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.

8.018 EMERGENCY MEDICAL TRANSPORTATION

8.018.1. DEFINITIONS

8.018.1.A. Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.018.1.B. Client means a person enrolled in the Medical Assistance Program.

8.018.1.C. Emergency Medical Services (EMS) Provider means an individual who has a current and valid emergency medical service provider certificate issued by the Department of Public Health and Environment (CDPHE) and includes Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), Emergency Medical Technician Intermediate (EMT-I), and Paramedic, in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two.

8.018.1.D. Emergency Medical Technician (EMT) means an individual who has a current and valid EMT certificate issued by CDPHE and who is authorized to provide basic emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two.

- 8.018.1.E. Emergency Medical Transportation means Ground Ambulance or Air Ambulance transportation during which Clients who are ill, injured, or otherwise mentally or physically incapacitated receive needed emergency medical services en route.
- 8.018.1.F. Facility means a general hospital, hospital unit, psychiatric hospital, rehabilitation hospital, Acute Treatment Unit (ATU), or Crisis Stabilization Unit (CSU), as well as any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH) or Skilled Nursing Facility (SNF), community mental health centers, federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers (ASCs), any other location furnishing dialysis services outside of the End Stage Renal Disease (ESRD) facility, and the beneficiary's home..
- 8.018.1.G. Fixed-Wing Air Ambulance means a fixed-wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.
- 8.018.1.H. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.
- 8.018.1.I. Interfacility Transportation means transportation of a Client from one Facility to another Facility.
- 8.018.1.J. Life-Sustaining Supplies means oxygen and oxygen supplies required for life-sustaining treatment during transport via ambulance.
- 8.018.1.K. Mileage means the number of miles the Client is transported in the ambulance.
- 8.018.1.L. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment that is covered by the Colorado Medical Assistance Program under Section 8.014. Non-emergency care may be scheduled or unscheduled. This may include urgent care transportation and hospital discharge transportation.
- 8.018.1.M. Paramedic means an individual who has a current and valid Paramedic certificate issued by CDPHE and who is authorized to provide acts of advanced emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two. For the purposes of these rules, Paramedic includes the historic Emergency Medical Service Provider level of EMT-Paramedic (EMT-P).
- 8.018.1.N. Paramedic with Critical Care Endorsement means an individual who has a current and valid Paramedic certificate issued by CDPHE and who has met the requirements in CDPHE rule to obtain a critical care endorsement from CDPHE and is authorized to provide acts in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight relating to critical care, as set forth in C.R.S. § 25-3.5-206.
- 8.018.1.O. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.
- 8.018.1.P. Specialty Care Transport (SCT) means interfacility Ground Ambulance transportation of a critically injured or ill Client from a stabilizing hospital to a hospital with full capabilities to treat the Client's case. SCT is necessary when a Client's condition requires ongoing care during transport at a level of service beyond the scope of the EMT, that must be furnished by one or more health professionals in an appropriate specialty area including, but not limited to, nursing, emergency medicine, respiratory care, cardiovascular care, or a Paramedic with Critical Care Endorsement.

8.018.2. CLIENT ELIGIBILITY

8.018.2.A. Emergency Medical Transportation is a benefit for all Colorado Medical Assistance Program Clients who are ill, injured, or otherwise mentally or physically incapacitated and in need of immediate medical attention to prevent permanent injury or loss of life.

8.018.3. PROVIDER ELIGIBILITY

8.018.3.A. Providers must enroll with the Colorado Medical Assistance Program as an Emergency Medical Transportation provider to be eligible for reimbursement. Enrolled Emergency Medical Transportation providers must:

1. Meet all provider screening requirements in Section 8.125.
2. Comply with commercial liability insurance requirements.
3. Maintain and comply with the appropriate licensure:
 - a. Ground Ambulance license as required by CDPHE statute at C.R.S. § 25-3.5-301 and 6 CCR 1015-3, Chapter Four.
 - b. Air Ambulance license as required by CDPHE statute at C.R.S. § 25-3.5-307 and 6 CCR 1015-3, Chapter Five.
4. License, operate, and equip Ground and Air Ambulances in accordance with federal and state regulations.

8.018.4. COVERED SERVICES

8.018.4.A. Emergency Medical Transportation is a covered service when medically necessary, as defined in Section 8.076.1.8., and in accordance with this Section 8.018.4.

8.018.4.B. Ground Ambulance

1. The following Ground Ambulance Emergency Medical Transportation services are covered:
 - a. Transportation to the closest, most appropriate Facility.
 - b. Basic life support (BLS) or advanced life support (ALS) required to maintain life during transport from the Client's pickup point to the treating Facility.
 - i. BLS includes:
 1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;
 2. Suctioning en route (not deep suctioning); and
 3. Airway control/positioning.

- ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference. This incorporation by reference excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), 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.
 1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.
 2. ALS Level 2 includes:
 - a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or
 - b. The provision of at least one of the following ALS procedures:
 - i. Manual defibrillation/cardioversion.
 - ii. Endotracheal intubation.
 - iii. Central venous line.
 - iv. Cardiac pacing.
 - v. Chest decompression.
 - vi. Surgical airway.
 - vii. Intraosseous line.
 - c. Specialty Care Transport when medically necessary to reach the closest, most appropriate Facility.
 - d. Department-approved supplies used during Emergency Medical Transportation, including Life-Sustaining Supplies, are separately reimbursable when medically necessary.

8.018.4.C. Air Ambulance

1. Air Ambulance Emergency Medical Transportation services are covered when:
 - a. They meet the criteria at Section 8.018.4.B.1.a.-b.; and
 - b. The point of pick up is inaccessible by a Ground Ambulance, or great distances or other obstacles prohibit transporting the Client by land to the nearest appropriate medical Facility.

8.018.4.D. Interfacility Transportation

1. Interfacility Transportation is covered when:
 - a. The Client requires a transfer from one Facility to another.
2. Interfacility Transportation can be provided via Ground or Air Ambulance.

8.018.5. NON-COVERED SERVICES AND GENERAL LIMITATIONS

8.018.5.A. The following services are not covered or reimbursable to Emergency Medical Transportation providers as part of an Emergency Medical Transportation service:

1. Waiting time and cancellations.
2. Transportation of additional passengers.
3. Response calls when determined no transportation is needed or approved.
4. Charges when the Client is not in the vehicle.
5. Non-benefit services (e.g., first aid) provided at the scene when transportation is not necessary.
6. Transportation which is covered by another entity.
7. Transportation to local treatment programs not enrolled in Colorado Medical Assistance Program.
8. Transportation of a Client who is deceased prior to transport.
9. Pick up or delivery of prescriptions or supplies.
10. Transportation arranged for a Client's convenience when there is no reasonable risk of permanent injury or loss of life.
11. Transportation to non-emergency medical appointments or services. See Section 8.014 for NEMT services.

8.018.6. PRIOR AUTHORIZATION

8.018.6.A. Prior Authorization is not required for Emergency Medical Transportation.

8.040 RECOVERIES FROM PROVIDERS

In the event that an audit or other competent evidence (e.g. information provided by another government agency) reveals that a Provider is indebted to the State for any reason, the Department shall recover this amount either through a repayment agreement with the Provider, by offsetting the amount owed against current and future claims of the Provider, through litigation, or by any other appropriate action within its legal authority.

8.040.1 ENROLLMENT OF PROVIDERS

Before claims can be accepted for payment for goods and services provided to eligible clients, the provider of goods and services shall be enrolled in the Medical Assistance program and assigned a provider number.

8.040.1.5 NATURE OF DEPARTMENT'S AGREEMENTS WITH HEALTH CARE PROVIDERS

- A. Pursuant to its authority under 25.5-1-104(4), C.R.S. and 25.5-1-201(1)(a), C.R.S., the Department enters into agreements with qualified health care providers for the provision of and payment for medical care, goods, and services to eligible persons. The Department has extended, and continues to extend, an open invitation to all qualified health care providers to enter into such agreements. This regulation clarifies that the Department's duty to comply with federal law requires that it enter into agreements with qualified health care providers to create a mechanism for payment to those providers, be they individuals or entities, who provide goods to or perform services for the eligible persons served by the Department's programs.
- B. Each qualified provider that enters into a "qualified agreement" shall be deemed to have participated in an open, public invitation (to more than three parties) to provide services to the eligible persons served by the Department's programs.
- C. For the purposes of this regulation, a "qualified agreement" means an agreement for the provision of or payment for medical care, goods, or services, to the eligible persons served by the Department's programs, by and between the Department and a qualified health care provider and, for these purposes, a "qualified health care provider" means an individual or an entity that:
 - 1) Has been assigned a Medicaid provider number for the purpose of allowing a payment through the Medicaid Management Information System;
 - 2) Has been assigned a CHP+ provider number; or
 - 3) Is otherwise approved by the Department to receive payments for the provision of medical care, goods, or services through the Department's fiscal agent(s).

8.040.2 SUBMISSION OF CLAIMS

Effective July 1, 1994, all Medical Assistance program providers shall be required to transmit in an approved electronic format to the fiscal agent for the Department all claims for goods and services which are benefits of the Medical Assistance program provided to eligible clients. Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the Department.

A transaction fee shall be required for each electronic claim transmission. This transaction fee shall be collected from the provider against current and future claims of the provider through a reduction in claim reimbursement and shall be so described on the Medicaid Remittance Statement.

Required information concerning the recipient, the service, charges, and provider shall be submitted in the prescribed format. Records verifying the type of service provided, the signed state approved certification statements and agreements which serve as a contractual basis for payment, and required client information or additional documentation which can be matched to the claim for services shall be retained in the provider's file for six years. This documentation shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents.

A. Hard Copy Claims

Hard copy (i.e., paper) claim forms shall be submitted only by authorization of the Department. The state approved certification statements contained on the claim form become effective and serve as a contractual basis for payment when the provider signs the form.

B. Automated Medical Payments System/Electronic Transfer of Claims

All providers shall be required to transmit claims for goods and services in the approved electronic format to the fiscal agent for the Department. Only those electronic formats which have been approved by the fiscal agent will be accepted for Automated Medical Payments System.

Before a provider can submit claims electronically, either directly to the fiscal agent or through a vendor or billing service, state approved provider certification agreements which contain all state approved certification statements and conditions shall be signed and accepted by both the provider and the Department. The state approved certification statements become effective and serve as a contractual basis for payment once the provider signs the form. A billing service shall also have a state approved billing service agreement signed and accepted by the Department before any claims will be accepted. The content of the agreements shall be determined by the Department.

If a provider chooses to submit claims for payment directly to the fiscal agent, source documents and source records used to create the claims shall be maintained in such a way that all electronic media claims can be readily associated and identified. These source documents, in addition to any work papers and records used to create electronic media claims, shall be retained by the provider for six years and shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents.

A corporation composed of satellite facilities with a common ownership may be considered as a primary provider and bill as such even though each individual facility has a provider number. However, the submitted claims shall identify the facility providing the services. Original source documents used to create the claims transmission shall be maintained at the facility for six years.

If a provider utilizes a billing service to transmit claims, the provider shall provide source documents and any other data transfer materials necessary to create the electronic claim. The billing service shall retain the source documents and data transfer materials for a six year period except when these items are maintained by the provider. Original source documents and data transfer materials shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the Department, and the Medicaid Fraud Control Unit and their authorized agents. If the provider furnishes the information to the billing service on a computer disc or some other method of electronic transmission, then the source documents used to create the disc or transmission shall be retained by the provider for six years and made readily available and produced upon request.

If the billing service goes out of business, then upon cessation of business, the billing service shall immediately return all documents to each individual provider.

Upon receipt of the electronic transmission, the fiscal agent will process the claims to the M.M.I.S. If the transmission is rejected, the fiscal agent shall send an electronic acknowledgement of rejection to the sender. Claims denied through the M.M.I.S. shall be described on the Medicaid remittance statement.

Electronic transmission of claims shall be required of any provider or billing service. The Department also reserves the right to reject any electronic claims transmission methods.

Failure of the provider or billing service to maintain and certify appropriate records as required by the state approved provider agreements constitutes breach of the state approved provider agreement, and entitles the Department to recover any payments for goods and services made to the provider and to terminate any state approved provider agreement. Thirty day written notice by registered mail shall be used by either party to terminate a state approved provider agreement unless the Department determines that good cause as defined in 8.076.1.7. exists in which immediate termination is necessary. Recovery may be accomplished by withholding the amount from future payments or requiring the provider to make payments directly to the Department as described in 8.040.

Electronically submitted claims must have a certification field indicating that the sender has verified that the claim information transmitted is true and correct. A hard copy of this transmittal will be kept on file at the provider's or billing service's place of business. All claim transmissions which require a state authorized attachment for the purposes of reimbursement or certification of service, will be submitted on hard copy (i.e., paper) and maintained with the providers' original source documents for a period of six years.

8.041 Claims Editing

8.041.1 DEFINITIONS

Current Procedural Terminology (CPT) means the common medical procedure codes used for the purpose of billing medical services as defined by the American Medical Association (AMA).

Fiscal Agent means a vendor who is contracted by the Department to process and maintain the Medicaid Management Information System (MMIS) for purpose of processing claims.

Healthcare Common Procedural Coding System (HCPCS) means an alpha numeric code set as defined by CMS used for the purpose of billing services that are not identified under CPT.

Medically Unlikely Edits (MUE) means units of service edits. This edit restricts the maximum units of services per claim line that may be billed for a procedure code.

National Correct Coding Initiative (NCCI) means a set of claim edits developed by the Centers of Medicare and Medicaid Services (CMS) to promote NCCI methodologies and control improper coding leading to improper Medicaid payments.

Procedure to Procedure edit means the prevention of certain procedure codes from being billed with other procedure codes for the same patient by the same practitioner on the same date of service.

Remittance Statement means the electronic or hard copy statement sent by the Medicaid fiscal agent to advise a provider of claims reimbursement or claims status.

8.041.2 AUTHORITY

8.041.2.A Pursuant to Colorado Revised Statute §25.5-4-300.7 the Department is authorized to implement and maintain a system for reducing medical services coding errors in Medicaid claims submitted to the state department for reimbursement. The system shall include automatic, prepayment review of Medicaid claims through the use of nationally recognized correct coding methods in MMIS.

8.041.2.B The Department will utilize a claims editing program to automatically review claims prior to payment to identify and correct improper coding for professional and outpatient services claims pursuant to Colorado Revised Statute §25.5-4-422(3). The claims editing program will recommend that the Department approve for payment, deny, or modify providers' submitted claims. The claims editing program will utilize a nationally recognized standardized method of processing claims for professional and outpatient services using clinical logic based on the most Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD), American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), and nationally recognized specialty practice guidelines.

8.041.3 NCCI PAYMENT METHODOLOGIES

8.041.3.A All providers shall report services performed on and rendered to clients by submitting claims using the HCPCS/ CPT codes designated by the Department. The use of these codes will be limited to providers who submit claims that are reimbursed based on the CPT code. Claim forms containing these codes are submitted to the Fiscal Agent for payment. NCCI methodologies include a set of edits, a definition of the type of claims subject to the edits, and rules regarding the application of the edits and provider appeals of denied payments. Claims submitted by providers shall be edited according to the six NCCI methodologies defined within the rule:

1. NCCI procedure to procedure edits for practitioners and Ambulatory Surgical Centers (ASC) services.
2. NCCI procedure to procedure edits for out-patient hospital services reimbursed based on CPT codes.
3. NCCI procedure to procedure edits for Durable Medical Equipment (DME) claims.
4. MUE units of service edits for practitioner and ASC services.
5. MUE units of service edits for out-patient hospital services reimbursed based on CPT codes.
6. MUE units of service edits for provider claims for Durable Medical Equipment (DME).

8.041.3.B The Department shall apply the following types of NCCI edits for services performed by the same provider for the same client on the same date of service.

1. Procedure-to-procedure edits (also known as Column I/Column II define pairs of HCPCS/ CPT codes) that should not be reported together.
2. MUEs (also known as units-of-service edits) define for each HCPCS/CPT code the maximum number of units of service allowable for each (e.g., claims for excision of more than one gallbladder or more than one pancreas).
3. Providers' services shall be denied by line item for the HCPCS/CPT code that is rejected by one of the NCCI edits in the above methodology.

8.041.4 PROVIDER APPEALS

8.041.4.A Providers may submit an appeal for denied line items due to NCCI edits in accordance with 10 CCR 2505-10 Sections 8.049 and 8.050.

8.041.5 REMITTANCE STATEMENTS

8.041.5.A A system of electronic remittance statements shall be used by the Department's Fiscal Agent to advise all Medicaid providers of claims reimbursement or claims status unless hard copy remittance statements are specifically authorized by the Department.

8.042 UTILIZATION OF A CASH SYSTEM OF ACCOUNTING

8.042.1 PROGRAMS UTILIZING THE CASH SYSTEM OF ACCOUNTING

Effective Fiscal Year 05-06 and ongoing, The Department shall utilize the cash system of accounting regardless of the source of revenues involved, for the following appropriations:

- A. Medical Services Premiums Long Bill group.
- B. Medicaid Mental Health Community Programs Long Bill group.
- C. Medical Programs administered by the Department of Human Services except for the administration of such programs. This includes the following Long Bill line items:
 - 1. Child Welfare Services
 - 2. Mental Health Community Programs, Goebel Lawsuit Settlement
 - 3. Residential Treatment for Youth (H.B. 99-1116)
 - 4. Mental Health Institutes
 - 5. Alcohol and Drug Abuse Division, High Risk Pregnant Women Program
 - 6. Community Services Adult Program Costs and CCMS Replacement – Medicaid Funding
 - 7. Federally – matched Local Program Costs
 - 8. Regional Centers – Medicaid Funding
 - 9. Services for Children and Families – Medicaid Funding
 - 10. Division of Youth Corrections – Medicaid Funding
- D. Nurse Home Visitor Program Long Bill line item.
- E. SB 97-101 Public School Health Services Long Bill line item.
- F. University of Colorado Family Medicine Residency Training Programs Long Bill line item.

8.042.2 PROGRAMS UTILIZING THE CASH SYSTEM OF ACCOUNTING

Effective Fiscal Year 07-08 and ongoing, The Department shall utilize the cash system of accounting regardless of the source of revenues involved, for the following appropriations:

- A. Services for Old Age Pension State Program Clients.
- B. Children's Basic Health Plan Premium Costs and Dental Benefit Costs.

- C. Medicare Modernization Act of 2003 State Contribution Payment.

8.043 TIMELY FILING REQUIREMENTS

.01 Effective 10/1/93, all claims for services provided to eligible Medicaid recipients must be received by the fiscal agent within 120 days from the date of service or 120 days from the Medicare processing date for all Medicare Crossover claims.

.02 Timely Filing Extensions for Circumstances Beyond the Control of the Provider

A. Delayed Processing by Third Party Resources

Medicaid is always the payer of last resort; however, if the initial timely filing period expires because of delays by the third party insurer in providing third party payment or denial documentation, the claim will be considered timely if it is received within 60 days from the date of the third party payment or denial or within 365 days from the date of service, whichever occurs first. A copy of the third party payment voucher or letter of denial must be attached to the claim form or the claim will be denied.

B. Delayed/Retroactive Recipient Eligibility

If the initial timely filing period expires because of delays by the county in establishing recipient eligibility or because recipient eligibility is back-dated, the claim will be considered timely; if it is received within the applicable initial timely filing period from the date that the recipient appears on the state eligibility files. Each claim must be accompanied by an authorized notification from the county department of social services which verifies the delayed or retroactive eligibility, and states the date when such action was entered on the eligibility system or the claim will be denied.

C. In all other instances, including possible exceptions to 8.043.02, A. and B. above, and 8.043.03 following, where extenuating circumstances beyond the provider's control allegedly existed, such circumstances as might have existed must be thoroughly documented and submitted as a reconsideration to the fiscal agent's Medicaid Exceptions Unit. However, employee negligence in carrying out their duties or employer negligence in making sufficient and well-trained employees available or in properly monitoring contractual employees/agents will not be considered extenuating circumstances beyond the control of the provider.

.03 Rebills/Adjustments/Reconsiderations

Denied and incorrectly paid claims may be resubmitted to the fiscal agent at any time during the initial timely filing period. However, if the initial timely filing period has expired, the fiscal agent must receive the rebill or adjustment/reconsideration request within 60 days from the latest Remittance Statement (RS) run date or the latest other written notification of adverse action. Copies of all Medicaid Remittance Statements and/or other written notifications of adverse action documenting initial and subsequent timely filing within the 60-day limit must be attached to the claim form or the rebill or request for adjustment/reconsideration will be denied.

.04 All original claims, rebills of denied claims, requests for adjustment of incorrectly paid claims, or requests for reconsideration of denied or incorrectly paid claims to the fiscal agent's Medicaid Exceptions Unit must be received by the fiscal agent within the applicable timely filing period; and, it is the provider's responsibility to ensure that this receipt occurs.

A claim, whether filed for the first time, rebilled, or submitted for adjustment/reconsideration, is considered to be filed when the fiscal agent documents receipt of that claim. Dated claim signatures, certified mail receipts and postmarks, or internal office logs (computerized or manual), for example, shall not constitute filing for the purpose of meeting the timely filing requirements of this manual and the controlling federal regulations. The date of receipt is the date the fiscal agent receives the claim, as indicated by a date stamp, or an imprinted Transaction Control Number assigned by the automated claims processing system - on the claim.

If an original claim, a rebill of a denied claim, a request for adjustment of an incorrectly paid claim, or a request for reconsideration of a denied or incorrectly paid claim to the fiscal agent's Medicaid Exceptions Unit is not acknowledged in written/printed form within thirty (30) days, it is the responsibility of the provider to inquire concerning its status, or resubmit. The weekly Medicaid Remittance Statement shall be proper and sufficient notification of fiscal agent action resulting from any provider request or submittal.

- .05 All valid claims must be paid within 12 months from the date of receipt, except in the following circumstances:
- A. This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system; that is, claims that are paid on the basis of a provisional payment rate set prospectively for an accounting period, and in which payments may be retrospectively adjusted on the basis of the cost experience during the accounting period.
 - B. If a claim for payment under Medicare has been filed in a timely manner, payment may be made for a Medicaid claim relating to the same services within 6 months of notice of the disposition of the Medicare claim.
 - C. The time limitation does not apply to claims from providers under investigation for fraud or abuse.
 - D. Payment may be made at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it, including the resolution of an administrative reconsideration or appeal.

8.045.1 PROHIBITION AGAINST PROVIDER REASSIGNMENT OF CLAIMS TO BENEFITS

For purposes of this section, the following definitions shall apply:

- a. "Organized Health Care Delivery System" is a public or private organization for delivering health services. The system may include, but is not limited to, a clinic or a group practice prepaid capitation plan.
- b. "Factor" is an organization; i.e., collection agency or service bureau, which, or an individual who, advances money to a provider for his accounts receivable which the provider has assigned or sold, or otherwise transferred, including transfer through the use of a power of attorney, to this organization or individual. The organization or individual receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. For purposes of this regulation, the term "factor" does not include business representatives, such as billing agents or accounting firms as described within this section.

- .11 No payment under the State Medical Assistance program for any care or services furnished to an eligible individual by a health care provider shall be made to anyone other than that provider, except as specified in this section.
- .12 Payments may be made to other than the provider of service when:
- a. That payment is made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order;
 - b. That payment is made to a business agent (such as a billing service or accounting firm) who renders statements and receives payments in the name of the provider, if the agent's compensation for this service is:
 - (1) Reasonably related to the cost of processing the billings,
 - (2) Not related on a percentage or other basis to the dollar amounts to be billed or collected, and
 - (3) Not dependent upon the actual collection of payment.

With respect to physicians, dentists or other individual practitioners, payment may be made:

- a. To the employer of the physician, dentist, or other practitioner if the practitioner is required as a condition of his employment to turn over his fees to his employer; or
 - b. To a foundation, plan, or similar organization, including a health maintenance organization, which furnishes health care through an organized health care delivery system if there is a contractual arrangement between the organization and the person furnishing the service under which the organization bills or receives payments for such person's services.
- .14 Payment under the Medical Assistance program for any care or service furnished to an eligible individual by a provider shall not be made to or through a factor, either directly, or by virtue of a power of attorney given by the provider to the factor.

8.049 RECONSIDERATION/APEAL OF ADVERSE ADMINISTRATIVE ACTION

8.049.01 ROLE OF THE FISCAL AGENT

- A. The fiscal agent is authorized by the Colorado Department of Social Services to recognize and apply all applicable State and Federal rules and regulations to process claims to satisfactory claim payment. Adverse administrative action by the fiscal agent through routine fiscal agent operations which results in the reduction or claim denial to a Medicaid provider may be submitted for reconsideration. Providers shall submit rebills and adjustment requests through routine fiscal agent operations until all routine processing procedures have been exhausted.

- B. If satisfactory resolution is not obtained through routine fiscal agent operations, the provider may file a written reconsideration with the fiscal agent's Medicaid Exceptions Unit. The provider must provide documentation essential to review the request for reconsideration. Copies of all Medicaid Remittance Statements (RS) and other written notification of adverse action documenting initial and subsequent timely filing, along with a signed copy of the original claim (including original attachments), and a brief explanation of the nature of the reconsideration must be submitted. The Request for Reconsideration must clearly be identified by attaching a designated Request for Reconsideration form to the claim or by identifying the word "Reconsideration" on the face of the claim form. Requests for reconsideration that do not include a completed claim form will be returned to the provider.
- C. Requests for reconsideration will be reviewed and the result of the review will, upon completion, be reported on the Medicaid Remittance Statement.

8.049.02 FINAL ADMINISTRATIVE APPEAL

Adverse decisions of the fiscal agent's Medicaid Exceptions Unit or decisions made by state Medicaid in exceptional circumstances may be appealed to the Office of Administrative Courts, as set forth in the PROVIDER APPEALS AND HEARING section of this manual.

8.050 PROVIDER APPEALS

8.050.1 DEFINITIONS

- 1. Adverse Action means:
 - a. The Department or its designees makes a finding of fact or interpretation of rules that results in a determination that goods or services were not medically necessary; results in identification of overpayments; or results in a reduction in, or denial of, other specific payments under the Medical Assistance program.
 - b. The denial, non-renewal or termination of a Provider agreement.
 - c. The denial of, or request for additional information regarding an application for Medicaid Certification of a Nursing Facility pursuant to Section 8.430.
 - d. The suspension of payments due to a determination of a credible allegation of fraud.
- 2. Mailed means caused to be directed, transmitted, or made available and includes, but is not limited to:
 - a. The use of the United States Postal Service;
 - b. The use of electronic mail (e-mail);
 - c. Making a notice available for retrieval through the Internet or an internet application, as long as notification of the availability is provided through e-mail;
 - d. The use of private courier or delivery services; and
 - e. The use of facsimile (fax) machines.
- 3. Medical assistance shall have the meaning defined in Section 25.5-1-103(5), C.R.S.

4. Provider means any person, public or private institution, agency, or business concern enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods.

8.050.2 NOTICE OF ADVERSE ACTION

8.050.2.A. A notice of Adverse Action shall be in writing, Mailed to the Provider, and include the following:

1. A statement of what action the Department intends to take.
2. The reasons for the intended action and the applicable regulations in support of that action.
3. Information about appeal rights.

8.050.2.B. A notice of Adverse Action regarding a nursing facility's rate determination shall include a description of the method of rate calculation, the recommended or proposed audit adjustments with an explanation of adjustments and the final rate established.

8.050.2.C. A notice of Adverse Action regarding a determination of overpayment(s) following a review or an audit of a provider shall include the offer of an informal reconsideration of the review or audit findings and notice that no recovery of the overpayment will be implemented until such informal reconsideration, if requested, has been completed.

8.050.3 PROVIDER APPEALS

8.050.3.A. A Provider, other than a nursing facility whose notice of Adverse Action is regarding a rate determination, may appeal a notice of Adverse Action by filing a written appeal within thirty (30) calendar days from the date on the notice of Adverse Action. The appeal shall be filed with the Office of Administrative Courts, Department of Personnel and Administration 1525 Sherman Street, Fourth Floor, Denver, CO 80203.

8.050.3.B. The appeal shall specify the basis upon which the Provider appeals the Adverse Action.

8.050.3.C. The date of filing the appeal shall be the date the Office of Administrative Courts receives the appeal. Failure to file a timely appeal shall result in dismissal of the appeal.

8.050.3.D. No recovery of an overpayment shall be implemented until the appeal process has been completed.

8.050.4 NURSING FACILITY RATE DETERMINATION APPEALS

8.050.4.A. Mandatory Informal Reconsiderations

1. A nursing facility, whose notice of Adverse Action results from its rate determination, may file a written request for informal reconsideration with the Department within thirty (30) days of the date the rate determination letter is mailed or the date that the nursing facility is notified that an electronic copy of the rate determination letter is available for review, whichever is later. The request shall state, with specificity, the adjustments to the cost report the nursing facility wants reconsidered and the nursing facility's position as to each adjustment.

2. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.
 3. When the first rate letter that incorporates a nursing facility's new appraised value is issued or made available electronically to the facility, the nursing facility may file a written request with the Department for informal reconsideration of the appraisal within thirty (30) days of the date on the rate letter or the date that the facility was notified that an electronic copy of the rate letter is available for review, whichever is later. Failure to file an informal reconsideration as set forth in this section shall cause any subsequent reconsideration or appeal of the appraisal at issue to be untimely and the reconsideration or appeal shall be dismissed.
 4. Failure to file a written request for reconsideration as set forth in this section shall result in a waiver of the right to appeal the Adverse Action. Any issue not presented for informal reconsideration shall not be considered and shall not be appealable to the Office of Administrative Courts.
 5. At informal reconsideration, the Provider shall not be allowed to present any information that was not submitted during the audit process prior to the issuance of the rate determination. The end of the audit process is defined as the expiration of the proposed adjustment review period as specified in Sections 8.442.3.B and 8.442.3.C.
- 8.050.4.B. The nursing facility may file an appeal with the Office of Administrative Courts of the Department's written decision on the informal reconsideration within thirty (30) days of the date of the written decision. The appeal shall conform to the requirements of Section 8.050.3.
- 8.050.4.C. Should the Department not issue a written decision on the informal reconsideration within forty-five (45) days of the Department's receipt of the request for informal reconsideration, the nursing facility may file an appeal with the Office of Administrative Courts within thirty (30) days of the 45th day following receipt of the request for informal reconsideration.
- 8.050.4.D. Notwithstanding the position of the parties, their conduct or statements made during the informal reconsideration process, any subsequent appeal initiated by the nursing facility shall be a de novo proceeding. Neither the Department nor the nursing facility shall be bound by their positions, conduct or statements made as part of the informal reconsideration process. The evidence submitted by the nursing facility and considered at the de novo proceeding, shall be limited to that which was submitted during the audit process prior to the issuance of the rate determination being appealed. No new nursing facility information or documentary evidence shall be admissible at the de novo proceeding.
- 8.050.4.E. The administrative law judge (ALJ) may not under any circumstances alter the appraisal methodology used by the contract appraiser. The ALJ has no authority to consider appeals from providers requesting the use of any method for calculation of depreciation other than the cost valuation system used by the contract appraiser.
- 8.050.4.F. The ALJ may alter the findings of fact, judgments and opinions contained in the appraisal report (e.g. measurements, decisions regarding the depreciation components of effective age and building condition) when supported by the evidence.
- 8.050.5 EXEMPTIONS FROM MANDATORY INFORMAL RECONSIDERATION IN NURSING FACILITY RATE DETERMINATION APPEALS**
- 8.050.5.A. The following nursing facility rate issues are exempt from mandatory informal reconsideration.

1. In the case of Class I and Class II nursing facilities or private for-profit or non-profit nursing facility Class IV Providers, the nursing facility's right to appeal shall commence on the mailing date of the rate letter setting a rate based on the maximum reasonable cost calculation or on the date the facility array and other data used by the Department in its determination of the maximum reasonable rate is made available to Providers. This appeal period shall then expire thirty (30) days after the commencement date.
2. In the case of state-administered Class IV intermediate care facilities for individuals with intellectual disabilities which are not subject to maximum reasonable cost calculations, the nursing facility's right to appeal shall commence on the mailing date of the nursing facility's rate letter setting the final rate based on the facility's actual allowable audited costs as reported on the form MED-13. Such appeal period shall then expire thirty (30) days after the commencement date. The Office of Administrative Courts shall not conduct the appeal hearing. The appeal process shall be resolved by both agencies presenting their position to the Governor's office. The Governor's decision shall be binding on both agencies.
3. An appeal of the imposition of a civil money penalty or the denial of a Medicaid payment for a Medicaid-only certified nursing facility's failure to meet federal requirements for participation in Medicaid, shall follow the formal appeal process set forth in Section 8.050.3. The penalty shall not be enforced or collected until the Department sends a certified letter to the Provider explaining the penalty or the denial of payment. In cases where the Provider appeals the penalty, collection of the penalty shall be suspended until the ALJ adjudicates the appeal.

**8.050.6 INFORMAL RECONSIDERATIONS AND APPEALS OF OVERPAYMENTS
RESULTING FROM REVIEW OR AUDIT FINDINGS**

- 8.050.6.A. A Provider whose notice of Adverse Action results from a determination of overpayment(s), may file a written request for informal reconsideration with the Department within thirty (30) calendar days of the date of the notice of Adverse Action.
1. Requests made by telephone shall not be accepted.
 2. The written request shall include:
 - a. The specific overpayments the Provider wants reconsidered;
 - b. The Provider's position as to each overpayment; and
 - c. Documentation that has not already been provided to the Department that substantiates the Provider's position as to each overpayment.
 3. If a Provider files a written request for informal reconsideration of an Adverse Action and an appeal of the same Adverse Action before a decision has been rendered on the informal reconsideration, the appeal shall control, and the request for an informal reconsideration shall not be acted upon.
- 8.050.6.B. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.

8.050.6.C. The Department shall issue a written decision on the informal reconsideration within forty-five (45) calendar days of the date on which the Department received the request for informal reconsideration. The Provider may file a written appeal of the informal reconsideration decision no later than thirty (30) calendar days from the date of the informal reconsideration decision pursuant to Section 8.050.3.

8.050.6.D. If the Department is unable to issue a written decision on the informal reconsideration decision within the time period described at Section 8.050.6.C., then the Department shall notify the Provider of its inability to complete the decision. The Provider may file a written appeal no later than 30 calendar days from the date of the notice stating that the Department is unable to render an informal reconsideration decision pursuant to Section 8.050.3.

8.050.6.E. Notwithstanding the position of the parties, their conduct or statements made during the informal reconsideration process, any subsequent appeal initiated by the Provider shall be a de novo proceeding, and neither the Department nor the Provider shall be bound by their prior positions, conduct or statements.

8.050.6.F. No recovery of an overpayment shall be implemented until the informal reconsideration and appeals process has been completed.

8.050.7 CONDUCT OF HEARINGS

8.050.7.A. Except as otherwise specifically provided in these rules, the provisions of Section 24-4-105, C.R.S., as amended, shall apply to the conduct of fair hearings.

8.050.7.B. For nursing home appeals regarding appraisals, the ALJ shall not, under any circumstance, alter the appraisal methodology from the most recent Request for Proposal but may alter the finding of fact, judgments and opinions contained in the appraisal report if supported by the evidence.

8.057 RECIPIENT APPEALS

8.057.1 DEFINITIONS

Action means a termination, suspension or reduction of Medicaid, eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations with regard to a Level II Screen finding for the preadmission screening and annual resident review requirements.

Adverse determination means a determination with regard to a Level II Screen finding for the preadmission screening and annual review requirements that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.

Authorized representative means a person designated by the applicant or recipient to act on his/her behalf. Such authorization shall be in writing in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations located at 45 C.F.R. parts 160 and 164. A written designated power of attorney may substitute for the HIPAA compliant release.

Date of action means the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective. It also means the date of the preadmission screening and annual resident review determination.

Notice, other than that required to be provided by a nursing facility seeking to transfer or discharge a resident, means a written statement which contains:

1. A statement of what action the Department or its designee intends to take;
2. The reasons for the intended action;
3. The specific regulations that support, or the change in federal or state law that requires the action;
4. An explanation of
 - a. The individual's right to request an evidentiary hearing if one is available; or
 - b. In cases of an action based on a change in law, the circumstances under which a hearing will be granted.
5. The method by which the individual may obtain a hearing;
6. That the individual may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman at the hearing; and
7. An explanation of the circumstances under which Medicaid is continued if a hearing is requested.
8. An explanation of the applicant's or recipient's right to a county or service agency dispute resolution conference.

Notice required to be provided by a nursing facility seeking to transfer or discharge a resident means a written statement which contains, in addition to the requirements above:

1. The reason for transfer or discharge;
2. The effective date of the transfer or discharge;
3. The location to which the resident is transferred or discharged;
4. The name, address and telephone number of the State long term care ombudsman;
5. For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
6. For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

Request for a hearing means a clear expression by the applicant or recipient, or his/her authorized representative that he/she wants an opportunity to present his/her case to a reviewing authority.

8.057.2 ADVANCE NOTICE

- 8.057.2.A. Notice shall be mailed at least 10 calendar days before the date of the intended action except as permitted in 8.057.2.B and 8.057.2.C. Requirements for the timing of notice before the facility can transfer or discharge a resident shall be governed by 8.057.2.D and 8.057.2.E.

- 8.057.2.B. Notice for any action other than when a nursing facility seeks to transfer or discharge a resident, may be mailed less than 10 calendar days before the date of the intended action if:
1. The Department or its designee has factual information confirming the death of a recipient;
 2. The Department or its designee receives a clear written statement signed by a recipient that
 - a. The recipient no longer wishes services; or
 - b. The recipient gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information;
 - c. The recipient has been admitted to an institution where he/she is ineligible for further services;
 - d. The recipient's whereabouts are unknown and the post office return agency mail directed to him/her indicating no forwarding address;
 - e. The recipient has been accepted for Medicaid services by another State, territory or commonwealth;
 - f. A change in the level of medical care is prescribed by the recipient's physician; or
 - g. The notice involves an adverse determination made with regard to the preadmission screening and annual resident review requirements.
- 8.057.2.C. Notice for any action other than when a nursing facility seeks to transfer or discharge a resident, shall be sent 5 calendar days before the date of the action if:
1. The Department or its designee has facts indicating that action should be taken because of probably fraud by the recipient; and
 2. The facts have been verified, if possible, through secondary sources.
- 8.057.2.D. Except as specified in 8.057.2.E, the required notice when a nursing facility seeks to transfer or discharge a resident shall be at least 30 calendar days before the resident is transferred or discharged.
- 8.057.2.E. The required notice by a nursing facility before transfer or discharge shall be as soon as practicable when:
1. The safety of individuals in the facility would be endangered;
 2. The health of individuals in the facility would be endangered; or
 3. The resident's health improves sufficiently to allow a more immediate transfer or discharge because the resident no longer needs the services provided by the facility;

8.057.3 OPPORTUNITY FOR HEARING

- 8.057.3.A. An individual shall have an opportunity for a hearing where:

1. An application for services is denied or is not acted upon with reasonable promptness;
 2. The recipient requesting the hearing believes the action is erroneous;
 3. The resident of a nursing facility believes the facility has erroneously determined that he/she must be discharged; and
 4. An individual who believes the determination with regard to the preadmission and annual resident review requirements is erroneous.
- 8.057.3.B. An individual does not have the right to an opportunity for hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.
- 8.057.3.C. An individual does not have the right to an opportunity for hearing for a preadmission screening and annual resident review Level I Screen finding.
- 8.057.3.D. A provider of medical assistance or any other provider of goods and services to an applicant or recipient, shall not have the right to a hearing concerning an action or an adverse determination to an applicant or recipient.
- 8.057.3.E. A member of a Managed Care Organization shall exhaust the internal appeals process described at 8.209 prior to requesting a fair hearing.
- 8.057.3.F. Opportunity For County or Service Agency Dispute Resolution Conference. In addition to the opportunity for a hearing, an applicant/recipient shall have an opportunity to have their approval, denial, termination, suspension, or reduction of Medicaid benefits resolved through an informal dispute resolution conference. County and service agencies shall afford recipients the opportunity for informal dispute resolutions as follows:
1. An applicant/recipient who disagrees with a decision regarding their eligibility may request dispute resolution either in writing or by phone within 60 calendar days of the eligibility determination date listed on the Notice of Action (NOA). If available through the County or service agencies, applicants/recipients may use email to make a request.
 2. Within 10 calendar days after receipt of the request for dispute resolution the County or service agency, after a review of the case by for accuracy and completeness, shall notify the applicant/recipient, in writing, of the date, time, and location of the conference. The notification shall also include the applicant/recipient's rights to a state level appeal and a deadline date for requesting such an appeal.
 3. The County or service agency shall hold the conference within no more than 25 calendar days from the date the request was received unless both parties agree, in writing, to extend the date of the conference.
 4. The applicant/recipient shall have the choice to have the dispute conference held in person or by phone.
 5. The dispute resolution conference facilitator shall, within 3 business days, notify the applicant/recipient of the finding from the conference via U.S. Mail.
 6. If the finding is that the dispute has been resolved and the member has already filed an appeal, the County or service agency shall inform the applicant or recipient of the process for dismissing the appeal.

8.057.4 REQUEST FOR HEARING

8.057.4.A. The request for a hearing shall be in writing and contain:

1. The recipient or applicant's name, address and State Identification Number, if applicable;
2. The action, denial or failure to act promptly on which the requested appeal is based; and
3. The reason for appealing the action, denial or failure to act promptly.

8.057.4.B. The request for a hearing shall be filed with the Office of Administrative Courts:

1. Within 60 calendar days of the date of the notice of action.

8.057.4.C. The recipient or applicant or his/her authorized representative shall be entitled to examine the complete case file and any other documents to be used at hearing at a reasonable time before the hearing or during the hearing. Documents and information that are confidential as a matter of law shall be exempt from this requirement unless they are to be offered as evidence during the hearing.

8.057.4.D. If the recipient or applicant makes an oral request for a hearing to the Department or its designee, the Department or its designee shall prepare a written request for the individual's signature or have the individual prepare such a request.

8.057.4 E. Expedited Hearings

1. An applicant/recipient may request an expedited hearing if the appeal involves an issue where the application of the standard timeframe for making a decision may seriously jeopardize the applicant/recipient's life, health or ability to regain, attain, and maintain maximum function.
2. The process for requesting an expedited hearing shall be by the same method as prescribed in 8.057.4.A, B, C, and D.
3. Upon receipt of the request for expedited hearing, the Office of Administrative Courts shall contact the Department's Office of Appeals.
4. Upon notification by the Office of Administrative Courts, the Department's Office of Appeals shall determine whether **the application of** the standard timeframe for making a decision may seriously jeopardize the applicant/recipient's life, health or ability to regain, attain, and maintain maximum function.
5. Grant of a request. If the Office of Appeals grants a request for expedited hearing, the Office of Appeals must:
 - a. Make the decision to grant an expedited hearing no later than one business day after notification from the Office of Administrative Courts of the request for expedited hearing;
 - b. Give the individual prompt oral notice of this decision; and
 - c. Subsequently send to the individual at his or her last known address written notice of the decision. This notice may be provided within the written notice of hearing.

6. Denial of a request. If the Office of Appeals denies a request for expedited hearing, the Office of Appeals must:
 - a. Make this decision no later than one business day after notification from the Office of Administrative Courts of the request for expedited hearing;
 - b. Give the individual prompt oral notice of the denial that informs the individual of the denial and explains that the Office of Appeals will notify the Office of Administrative Courts to process the request for a non-expedite hearings; and
 - c. Subsequently send to the individual at his or her last known address and to the Department an equivalent written notice of the decision within 3 business days after the oral notice.
7. The decision, denying a request for expedited hearing, may not be appealed.
8. Timeframe for decision.
 - a. If the Office of Appeals accepts a request for expedited hearing, the Office of Appeals shall schedule a hearing, as expeditiously as the applicant/recipient's health condition requires, but no later than the end of the day after the decision to grant the hearing was made.
 - b. A decision on the hearing shall be made as expeditiously as the applicant/recipient's health condition requires, but no later than three business days after the Office of Appeals receives the request for an expedited appeal.
 - c. If the decision involves an eligibility issue, the decision on the hearing shall be made as expeditiously as the individual's health condition requires, but no later than seven business days after the Office of Appeals receives the request for an expedited appeal.
 - d. These time limits shall not apply if the Department cannot reach a decision because the applicant/recipient requests a delay or fails to take a required action, or if there is an administrative or other emergency beyond the Department's control. The Department must document the reasons for any delay in the record.
9. Hearing.
 - a. The scheduled hearing may be held in person or by phone and shall be recorded.
 - b. The Department's Executive Director, Medicaid Director, Medical Director or their designees may preside over the hearing.
10. Hearing Decision.
 - a. The Department's Executive Director, Medicaid Director, Medical Director or their designees shall make a decision within the required timeframe.
 - b. The Department's Executive Director, Medicaid Director, Medical Director or their designees shall give the individual prompt oral notice of this decision; and
 - c. Subsequently send to the applicant/recipient at his or her last known address written notice of the decision.

- d. The hearing decision shall constitute a Final Agency Decision for purposes of requesting judicial review, and Section 8.057.11 shall apply.

8.057.5 MAINTAINING SERVICES

8.057.5.A. Where the recipient requests a hearing before the date of action, the recipient's services may not be terminated or reduced until a final agency decision is rendered after the hearing unless:

1. It is determined at the hearing that the sole issue is one of federal or state law or policy; and
2. The recipient is promptly informed that services are to be terminated or reduced pending the hearing decision.

8.057.5.B. Where the action of the Department or its designee is sustained by the final agency decision, the Department or its designee may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section regarding maintaining services.

8.057.5.C. Continued Benefits During an SSA Appeal. If an individual receiving Medicaid based upon disability is determined by SSA not to be disabled, and he or she is not eligible for Medicaid on some other basis, Medicaid is continued during the 60-day period within which an SSA appeal may be filed. If the individual does not appeal the SSA decision within the 60-day period, Medicaid shall be terminated.

If an SSA hearing is requested within the 60-day period, Medicaid may not be terminated until a final decision is made after the SSA hearing. A final administrative decision occurs when the Medicaid recipient has no right to further administrative appeal with the SSA. The Department shall provide 10-days notice to the individual that Medicaid shall be terminated after the 60-day period if the individual fails to appeal the SSA decision.

8.057.5.D. Continuation or Reinstatement of Benefits After The Effective Date Of The Action. Where the recipient requests a hearing not more than 10 days after the date of the intended action, the recipient's services may be continued or reinstated until a final agency decision is rendered after the hearing if the recipient provides verification, in the form of a signed statement with supporting documentation, of one of the following circumstances.

1. The recipient's life, health, or safety will be impacted by the loss of benefits.
2. The recipient was unable to request a hearing before the date of action due to the recipient's disability or employment.
3. The recipient's caregiver or their authorized representative was unable to request a hearing before the date of action due to their health or employment.
4. The recipient did not receive the County's or designated service agencies notice prior to the effective date of the intended action.

8.057.6 DENIAL OR DISMISSAL OF REQUEST FOR HEARING

8.057.6.A. The request for hearing shall be denied or dismissed if:

1. The applicant or recipient withdraws the request in writing; or

2. The applicant or recipient fails to appear at a scheduled hearing without good cause. Good cause shall mean a sudden severe illness, an accident, or other particular occurrence which, by its emergent nature and drastic effect, prevented appearance at the hearing.

8.057.6.B. The applicant or recipient shall have 10 calendar days from the date of the notice of dismissal scheduled hearing to explain, in a letter to the Administrative Law Judge, the reason for his/her failure to appear. If the Administrative Law Judge finds that there was good cause for the nonappearance, the Administrative Law Judge shall schedule another hearing date.

8.057.7 FAIR HEARINGS

8.057.7.A. A hearing shall cover:

1. Action, denial or failure to act with reasonable promptness regarding eligibility or services;
2. Decisions regarding changes in the type or amount of services;
3. Decision by a nursing facility to transfer or discharge a resident; and
4. Determination with regard to the preadmission screening and annual resident review requirements.

8.057.7.B. Conference telephone hearings may be conducted as an alternative to face-to-face hearings. All applicable provisions of the face-to-face hearing shall apply to telephone hearings.

8.057.7.C. Upon receipt of notice of a Department hearing of an appeal, the county department shall arrange for a suitable hearing room appropriate to accommodate the number of persons, including witnesses, who are expected to be in attendance.

8.057.7.D. Except as otherwise specifically provided in these rules, the provisions of Section 24-4-105, C.R.S., as amended, shall apply to the conduct of fair hearings.

8.057.7.E. Hearings related to an applicant or recipient's disability determination, level of care determination or target group eligibility shall be held within 20 calendar days after the Office of Administrative Courts receives the request for a fair hearing unless the client demonstrates good cause for postponement of the hearing. Under no circumstances shall the hearing be conducted more than 45 calendar days after receipt of the request for a fair hearing.

8.057.7.F. In hearings which involve medical issues such as those concerning a diagnosis, an examining physician's report or a medical review team's decision, the Administrative Law Judge may order a medical assessment other than that in the record of the Department or its designee making the disability determination if the Administrative Law Judge considers such medical assessment necessary. The assessment shall be at the expense of the Department or its designee and shall be made part of the record.

8.057.7.G. The hearing shall be private unless the applicant or recipient requests, on the record, that the hearing be open to the public.

8.057.7.H. If the appellant is not fluent in English or has a language difficulty, the Department will arrange with county assistance to have present at the hearing a qualified interpreter who will be sworn to translate correctly.

8.057.8 INITIAL DECISIONS

8.057.8.A. The Administrative Law Judge shall promptly prepare and issue a written Initial Decision and file it with the Office of Appeals of the Department. Initial decisions shall be based exclusively on evidence introduced at the hearing.

8.057.8.B. The Administrative Law Judge shall issue the Initial Decision following a disability determination hearing, a level of care denial hearing or a target group eligibility hearing within 20 calendar days of the hearing date.

8.057.8.C. The Initial Decision shall be in writing and shall:

1. Summarize the facts;
2. Identify the regulations and evidence supporting the decision;
3. Advise the applicant or recipient that failure to file exceptions to the provisions of the Initial Decision shall waive the right to seek judicial review of a final agency decision affirming those provisions.

8.057.8.D. The Administrative Law Judge shall be bound by the Department's interpretation of statutes where the Department has regulations implementing such statutes.

8.057.8.E. The Administrative Law Judge shall have no jurisdiction or authority to determine issues of constitutionality or legality of the Department's regulations.

8.057.8.F. In hearings concerning disability determinations, the only factual issue to be determined by the Administrative Law Judge is whether the applicant or recipient meets the Medicaid definition of disability or blindness set forth in section 8.100.1. The Administrative Law Judge's determination shall be limited to whether or not the applicant or recipient met the definition of disability or blindness on the date that the disability determination was completed.

8.057.8.G. In hearings concerning level of care determinations, the only factual issue to be determined by the Administrative Law Judge is whether the applicant or recipient meets the level of care screen applicable to the program at issue. The Administrative Law Judge's determination shall be limited to whether or not the applicant or recipient met the level of care on the date that the level of care determination was completed.

8.057.9 REVIEW BY THE OFFICE OF APPEALS

8.057.9.A. The Department's Office of Appeals shall promptly serve the Initial Decision upon each party to the fair hearing by first class mail. Party shall include the Department even if the Department has not previously appeared as a party to the appeal.

8.057.9.B. Any party seeking to reverse, modify or remand the Initial Decision shall file exceptions with the Office of Appeals within 15 calendar days, plus 3 calendar days for mailing, of the date the Initial Decision is mailed to the parties.

8.057.9.C. Exceptions to Initial Decisions shall be in writing and shall state the specific grounds for reversal, modification or remand of the Initial Decision.

8.057.9.D. A written transcript of the hearing is required where the party filing the exceptions asserts that the findings of evidentiary fact in the Initial Decision are not supported by the weight of the evidence.

1. The party requiring a written transcript of the hearing shall request the written transcript from the Office of Administrative Courts prior to the filing of exceptions. If the written transcript is not filed with the exceptions, the exceptions shall state that a written transcript has been requested. The party shall comply with all applicable due dates. Prior to the due date for filing exceptions, the party may request, in writing, an extension of time to file either exceptions or the written transcript.
2. In cases where the applicant or recipient (Appellant) requests a written transcript in order to file exceptions based on findings of evidentiary fact, the Department shall pay the transcribing agency for the cost of one original transcript for the Office of Appeals, and one copy for the requesting applicant or recipient.
3. While review of the initial decision is pending, the submitted written transcript of the hearing shall be available for examination by any party to the appeal, during regular business hours of the Office of Appeal.

8.057.9.E. The Office of Appeals shall promptly serve a copy of the exceptions on each party by first class mail. Each party may file a written response to an exception filed by another party within 10 calendar days from the date the exceptions were mailed to the parties.

8.057.9.F. The parties shall not have the right to oral argument to the Office of Appeals.

8.057.10 FINAL AGENCY DECISIONS

8.057.10.A. The Final Agency Decision shall be based on the record except that the Office of Appeals may remand for rehearing if a party establishes in its exceptions that material evidence has been discovered which the party could not, with reasonable diligence, have produced at the hearing.

8.057.10.B. The record shall consist only of:

1. The written transcript of testimony and exhibits,
2. All papers and requests filed in the proceeding;
3. The initial decision of the administrative law judge; and
4. Any exceptions and requests filed in response to the initial decision of the administrative law judge.

8.057.10.C. The applicant or recipient shall have access to the record at a convenient place and time.

8.057.10.D. The Office of Appeals shall issue a Final Agency Decision within 90 calendar days, except as stipulated in 8.057.10.E, from the date the request for a hearing is received unless an extension has been granted to the applicant or recipient in which case the 90 calendar day period shall be increased accordingly..

8.057.10.E. The Office of Appeals shall issue a Final Agency Decision within 3 calendar days from the date the request for an expedited hearing is received.

8.057.11 NOTIFICATION OF DECISION

8.057.11.A. The applicant or recipient shall be provided, in writing, with:

1. A copy of the Final Agency Decision; and

2. Notification of his/her right to seek judicial review and the effective date of the Final Agency Decision for purposes of requesting judicial review.

8.057.11.B. For purposes of requesting judicial review, the effective date of the Final Agency Decision shall be the third day after the date the decision is mailed to the parties, even if the third day falls on Saturday, Sunday or a legal holiday.

8.057.12 CORRECTIVE ACTION

8.057.12.A. If the Final Agency Decision is favorable to the applicant or recipient, corrective action shall be taken, within three working days after the effective date of the Final Agency Decision, retroactive to the date the incorrect action was taken.

8.057.13 RECONSIDERATION OF FINAL AGENCY DECISION

8.057.13.A. A party may file a motion for reconsideration of a Final Agency Decision with the Office of Appeals:

1. Upon a showing of good cause for failure to file exceptions to the Initial Decision within the allowed 15 calendar day period; or
2. Upon a showing that the Final Agency Decision is based upon a clear or plain error of fact or law.

8.057.13.B. The motion for reconsideration shall be filed, in writing, with the Office of Appeals within 15 calendar days of the date that the Final Agency Decision is mailed to the parties. The motion shall state the specific grounds for reconsideration.

8.057.13.C. The Office of Appeals shall promptly serve a copy of the motion for reconsideration on each party by first class mail. Each party may file a written response to a motion for reconsideration filed by another party within 10 calendar days from the date the motion was mailed to the parties.

8.057.13.D. The Office of Appeals shall promptly serve a copy of its decision on the motion for reconsideration on all parties by first class mail.

8.057.14 INFORMAL CLIENT CONFERENCE IN DISABILITY DETERMINATIONS

8.057.14.A. Prior to the issuance of an action regarding an applicant or recipient's disability determination, the Department or the entity designated to conduct the disability determination shall provide the applicant or recipient with the opportunity for an informal conference, in person or by telephone, at which time the applicant or recipient may provide new or additional information relevant to the applicant or recipient's claim of disability or blindness.

8.057.14.B. If an action issues from the Department or the designated entity, the appeal procedures set forth in 8.057, Recipient Appeals, shall apply to disability determinations.

8.057.15 ALTERNATIVES TO INSTITUTIONAL CARE

8.057.15.A. Recipients who are determined to be likely to require a level of care available in an institution shall have the right to request a hearing where:

1. The recipient is not given the choice of home and community-based services as an alternative to the institutional care or

2. The recipient is denied the service of their choice or available provider of their choice.

8.058 REQUEST FOR PRIOR AUTHORIZATION

- 8.058.1 Certain services, supplies, equipment, and drug items are available as a benefit of the Medical Assistance program only with prior authorization from the Department or its designee. With respect to benefits not specifically dealt with elsewhere in the Volume VIII staff manual, prior authorization shall be requested by submission of a Request for Prior Authorization form, or in the case of dental services, submission of a Dental Claim form.
- 8.058.2 Upon receipt of a request for prior authorization which is inadequate or incomplete, the Department or its designee shall contact the requesting provider by phone or mail, as appropriate, within 10 working days to request the missing information.
- 8.058.3 Based upon medical information included on the appropriate request form, the Department or its designee shall approve or deny all requests for prior authorization within 10 working days following receipt of a complete and adequate request.
- 8.058.4 The provision of care, drugs, services, or equipment during an emergency situation is exempt from the regular prior authorization system. In such cases, benefits which would have been authorized in the absence of the emergency may be authorized retroactively. An emergency is defined as any condition in which care, drugs, services, or equipment must be immediately dispensed due to a life threatening condition or a condition requiring immediate medical intervention. The treating physician shall determine the existence of an emergency, and shall reduce the request to writing, including a description of the emergency. Such description shall serve as justification of the emergency benefits, and shall be submitted with a Form 10013 within 60 days following the emergency situation. The Department shall review the emergency request in order to determine the need for continuing or ongoing benefits arising from the emergency.

MED 100
 (2/83)

ADVANCE NOTICE OF ADVERSE ACTION CONCERNING MEDICAID BENEFITS

SI NO ENTIENDE ESTA NOTICIA, LLAME POR
 TELEFONO EL DEPARTAMENTO DEL CONDADO

IF YOU DO NOT UNDERSTAND THIS NOTICE, CALL
 YOUR COUNTY DEPARTMENT OF SOCIAL SERVICES

CASE NUMBER			CATG	
CNTY	BASIC	SUF		

I. The State Department of Social Services has determined from its records that it must reduce your Medicaid Benefits, or that it must suspend certain benefits, or that you are restricted to receiving certain benefits, or that you are to be locked in to particular providers. The proposed action, the reasons therefor and the applicable rules are as follows.

a. The proposed action is to:

POSTIVE DEPTS BENEFIT	TYPE SUSPENSE	RESTRICTED BENEFIT PROVIDER	LOCK IN PROVIDER	REDUCE PROVIDER	DATE EFFECTIVE ACTION

b. The reasons and rules which apply are:

-
-

II. If the State took an action which you think wrongs you and which involved interpretation of the law or the rules as applied in your particular situation, you have the right to a hearing before the State department of Administration to contest this decision. The hearing place, date, and time will be set by the Hearing Officer. You will be notified directly by the Hearing Officer in writing where and when the hearing shall be. You may be able to get an extension of this scheduled hearing date by calling the Hearing Officer. Your call or written request for extension, questions, request for further information, or other communication with State Staff or the Hearing Officer about this proposed action must be received two days before the proposed effective action date listed in Section I-B.

If you disagree with the above-described proposed action and want to appeal, i.e., have a State hearing, you must request a hearing in writing. If you want to do this, you must get your request in the mail not later than 15 days from the date shown in Part V of this form. If you do not come to the State hearing on the date and time set by the Hearing Officer, you will be considered as having abandoned the State level appeal, and the proposed action will be taken by the State department.

III. If you wish to have a hearing, you have the right to appear personally to examine papers and documents, to give additional facts or information, to confront, challenge, and cross-examine the people who made the decision, and to bring a lawyer or any other person you choose to represent you.

STATE DEPARTMENT STAFF SIGNATURE	TELEPHONE NO.	SIGNATURE OF IMMEDIATE SUPERVISOR

IV.

V. I certify that I have mailed this form as above completed to the above named individual by deposit of the same in the United States mail, postage prepaid, on the date shown.

SIGNATURE OF PERSON RECEIVING COPY (PRINT NAME AND ADDRESS)	DATE PLACED IN MAIL (PRINT)

EXPLANATION OF PRIOR NOTICE PROCEDURE,
APPEAL PROCESS, AND RIGHTS

The following is an explanation of the notice appearing on the other side of this form, the procedure which it initiates, and your rights of appeal. Generally, you are given one chance to appeal to the State. The State can not make the change it tells you about until the end of the prior notice period. The material below talks about these and other rights you have.

1. Prior Notice When the State department determines that it must take an action which adversely affects your Medical benefits, the State is required to provide an advance notice of such intended action to you at least 15 days before the date that it would become effective (which is "the prior notice period"). The notice must tell you what the State intends to do, why the action appears necessary, and the Department of Social Services' rule, or rules, which appear to be applicable and on which the intended action is based. This gives you time to receive the mailed notice, get further explanation from the State (or for you to provide additional information), to decide whether to go to the State hearing, and if so, to prepare for that hearing.

2. State Appeals After you get the prior notice, and if you disagree with the intended action and want to appeal, you must write to say that you want to appeal. This contact must be made within 16 days of the date this form was mailed to you as shown in Part V on the other side of this form.

All State evidentiary hearings are reserved and scheduled by the Hearing Officer. When there is good reason for a person not to be able to get to the hearing on the reserved day, an extension can be given, but you will have to call the Hearing Officer within the 15-day prior notice period to get this extension. If you do not come to the State hearing on the reserved day or get an extension, the conclusion is made that this hearing right is given up and the State will carry out its intended action. The State hearing is run by an individual who is not involved in your case and is required to be impartial. That person will make the decision as to whether the State-intended action is right or wrong. If it is determined to be wrong, the action intended will not be carried out; if the intended action is determined by the State Hearing Officer to be correct, the action will be carried out.

When you want to appeal something which is not covered in the notice process, you must start that appeal (get your request in the mail) not later than 15 days from the date the improper action took place.

The State department is required to give you full and complete explanations of actions it takes, so it is suggested that you get a full understanding from them as to what the action is before you file an appeal. However, the right to appeal is yours in any case.

If you want to start a State appeal, you should write a letter to:

Colorado Department of Social Services
Division of Hearing Officers
1525 Sherman Street, Room 207
Denver, Colorado 80203

Say in that letter that you want to appeal and why. If you need help to do this, you can ask anyone you desire to help you, or talk to a Legal Aid Office, or ask your County or State Social Services people to help you.

When such an appeal is received, you will get a letter from them explaining what will be done and the date, etc., for the appeal hearing. They also will tell you about who can come with you, present testimony, and other details about an appeal hearing.

You should be aware that the State and County are required to attempt collection or get repayment of all benefits provided you for which you are not entitled.

3. Interim Relief At any time during the appeal process concerning a suspension, reduction, or lock-in of benefits, you may request interim relief, i.e., that the action described upon the other side of this form be postponed until the appeal process is completed. If it can be shown that irreparable damage will occur if the action is completed, interim relief will be granted. Requests for interim relief should be directed to the Division of Hearing Officers at the address given above and should be accompanied by an appropriate statement regarding potential harm.

4. Judicial Review If you disagree with the decision from the State appeal, you have the right to apply for Judicial Review in the appropriate State District Court. Such requests for Judicial Review must be filed in accordance with the rules of civil procedure for Courts of Record in Colorado and must be filed within thirty days after the appeal decision becomes effective.

5. Discrimination If you believe that you have been discriminated against because of race, color, religion, sex, handicap, national origin, age, or political beliefs, you have a right to file a complaint with:

Colorado Department of Social Services or:
Complaints Section
1575 Sherman Street
Denver, Colorado 80203

The Secretary of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

8.061 USE OF OTHER RESOURCES IN THE PROVISION OF MEDICAL ASSISTANCE BENEFITS

- .1 Individuals are expected to utilize, to the extent possible, all those resources which are available to them through Social Security, Medicare or other private or public medical care programs which provide benefits to such individuals.
- .2 Benefits provided under the Medical Assistance Program (Medicaid) will not duplicate those available to the client from private insurance policies. (See Section 26-4- 106(4), C.R.S.)
- .3 Clients who are eligible for medical care or benefits through the Veterans Administration, Military Dependency (CHAMPUS), United States Public Health Service, or other health programs are expected to make maximum use of these services before Medical Assistance benefits are utilized.
- .4 If a client has primary health coverage through a third party (i.e., a commercial or individual policy, an HMO, PPO, automobile or worker's compensation policy), the client must utilize that primary third party coverage prior to utilizing Medicaid services.
- .5 If a client fails to comply with the primary health coverage requirements (including not using the primary coverage's provider network, not obtaining a referral or other cost containment provisions), the client will be liable to the provider for the health services and Medicaid will not be liable.
- .6 If a provider knowingly provides health services to a Medicaid client who is not enrolled into a client's primary health coverage, neither the client nor Medicaid will be liable for the costs of services.
- .7 If written or oral communication regarding the health coverage requirements is not provided to the client by the liable third party or the provider of service, then the client will not be liable for the service. The client will only be liable if written documentation exists that the client was provided with instructions regarding the plan requirements. The client will not be liable to the provider for the cost of health services if the client is unable to comply with the requirements of the primary health coverage due to an emergency medical condition. (See Section 26-4-403(1)(III)(A).
- .8 Emergency medical condition means the sudden, and at the time, unexpected onset of a health condition that required immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Benefits cannot be denied for conditions which a prudent lay person would perceive as emergency medical conditions as specified by the Division of Insurance Regulation 4-2-17, Section 6.G. (Vol. 8. Sec. 8.205 C,).
- .9 A client may enter into an agreement with a third party or provider whereby the client agrees to be personally liable for payment of services not covered by the third party or Medicaid. This agreement must set forth the specific services provided by the third party or provider, the approximate cost of services provided and the method of payment by the client. The agreement must be signed and dated by both the client and the third party or provider in advance of the services being rendered. (See Section 26-4-403 (1)(III)(B).
- .10 A client who becomes liable for medical services under this rule has the right to the formal adjudication process described at Section 8.058 of this staff manual, also known as the Fair Hearing process at which an Administrative Law Judge (ALJ) presides. An appeal to the ALJ shall be in writing.

8.061.2 RESPONSIBILITY FOR SECURING MEDICAL RESOURCE INFORMATION

- .21 The county department is required to secure information concerning the health insurance or other medical coverage of an individual at the time that individual applies or is predetermined eligible for public assistance. Such information relates to the name(s) and State ID. number(s) of the individual(s) covered by the medical coverage, the name of the insurance company, policy number, policy holder, the effective dates of the policy coverage, the address where the medical claim forms must be submitted, and any other information determined necessary for third party liability purposes. This information is to be entered on the State prescribed Client Health Resource Information Form (MS-10). The completed form will be given to the State Department (or its fiscal agent). The information so supplied will be entered into a computerized file and will serve as the basis for claims payment or denial.
- .22 The county must enter the required medical resource code for a client on either the AP-800 Financial and Medical Eligibility Reporting Form, PCS 100 or FCS 700, Family and Children Services/Child Welfare Medical Forms. This medical resource indicator will be available on the eligibility verification. Medical providers will be required to bill the resource listed (if applicable) before submitting the claim to the Medical Assistance Program for payment.
- .23 The individual providers, e.g., hospitals, physicians, home health agencies, etc., are required to make inquiry regarding other medical resources a client has at the time medical services are furnished. If the eligibility verification indicates that a resource appropriate to the medical service provided exists, that resource must pay or deny the claim before the Medical Assistance Program can be billed. It is the responsibility of providers to obtain any necessary assignment of benefits from the client.

8.061.3 RIGHT OF RECOVERY IN THIRD PARTY LIABILITY CASES

Section 26-4-403(3), as amended, establishes the State Department's right to recover the cost of medical care provided to an eligible Medicaid client when a third party is liable.

- .31 Examples of situations in which third party may be liable are: work-related injury covered by worker's compensation, automobile accidents, accident or personal injury claims.
- .32. County department staff shall report any and all possible cases of this type involving a Medicaid client to the State Department Specific information regarding the case should be provided whenever known. This includes date and nature of the accident, injuries sustained, name and address of potentially liable third party, name and address of client's attorney.

8.061.40 AGREEMENTS AND PROCEDURES UTILIZING OTHER AGENCY - RESOURCES

The State Department of Health Care Policy & Financing has working agreements with various agencies which provide medical care under other programs to individuals. To the extent possible, Medical Assistance Program benefits are to be coordinated with the activities and efforts made by other agencies. This includes details on how referrals are made and utilization of other agency benefits, etc.

8.062 SOCIAL SECURITY MEDICARE BENEFITS

**8.062.10 SOCIAL SECURITY "MEDICARE" HOSPITAL INSURANCE BENEFITS (HIB)
(PART "A")**

- .11 Individuals who receive financial benefits under OASDI or Railroad Retirement and are 65 years of age and over are automatically enrolled for HIB. All other persons must complete an application form for HIB.

- .12 Certain of the benefits provided under HIB have deductible provisions, co-insurance, or both. The State Department shall reimburse deductible and cost sharing amounts for skilled nursing homes at the Medicare or Medicaid maximum allowable reimbursement limits, whichever is the lesser. The State Department's reimbursement for hospital inpatient and hospital outpatient deductible and cost sharing shall not exceed Medicare reimbursement to the hospital.

8.062.20 SOCIAL SECURITY "MEDICARE" SUPPLEMENTARY MEDICAL INSURANCE BENEFITS (SMIB) (PART "B")

- .21 The State Department shall pay the monthly SMIB premium for all recipients of the Medical Assistance Program who are found eligible for participation by Social Security. These eligibles include:
- A. People 65 and over who have Medicare Part "A".
 - B. All other people 65 and over who are U.S. citizens, or aliens lawfully admitted to the U.S. and residing here for at least five years.
 - C. People under 65 who have been receiving monthly Social Security disability benefits under Title II for 24 months.
 - D. People under 65 who are eligible for Medicare Part "A" because they have chronic renal disease.

In addition to the charge for premium payment, individuals who have SMIB coverage are charged a yearly deductible, plus 20% of the Medicare maximum allowable reimbursement for services. The state department shall reimburse the deductible and cost sharing amounts for non-institutional services up to the Medicare or Medicaid maximum allowable limit, whichever is lower.

- .22 The county department is responsible for notification to the State Department, using the appropriate "Notice of Action" form, of individuals who are newly eligible or no longer eligible, and who are covered under SMIB.

8.062.30 METHOD OF ADMINISTRATION

Administrative arrangements have been made between the State Department and the Medicare fiscal intermediaries for payment of the deductibles and co-insurance payments to vendors.

8.062.40 REFUSAL TO APPLY FOR TITLE XVIII BENEFITS

In some instances, an individual who refuses to sign a Medicare Application can be determined to be incompetent and an application can be signed in his behalf by another person. The following is in accordance with a guidance statement from the Social Security Administration for such cases:

If a recipient is incompetent, the application for Medicare benefits (Form SSA-18) can be signed by someone else in his behalf. Such person can be the recipient's legal guardian, a relative, an interested friend, an authorized official of an institution where the individual may reside, or an authorized official of the county department (such as the director, a supervisor, or a caseworker, etc.). Where such an application is made for Medicare benefits only (as opposed to monthly money payments for Social Security Retirement or Survivor's benefits, etc.), there does not necessarily have to be a physician's statement concerning incompetency. The person making such an application must, however, enter a statement on the form, describing the recipient's condition to the extent necessary to leave no reasonable doubt regarding such condition. Only where doubt exists as to incompetency, need a doctor's statement be attached as to the person's incompetency for Medicare application.

8.062.50 USE OF CERTIFIED FACILITIES

When a recipient is hospitalized in a licensed hospital or utilized a licensed facility which is not certified, or accredited, as a participant in the Title XVIII Medicare Program, benefits under Title XVIII are unavailable for the care of the recipient. In such situation, the Medical Assistance Program will provide the recipient with emergency services only.

Whenever feasible, the county department shall encourage recipients to utilize certified facilities.

8.063 MEDICAL ASSISTANCE ESTATE RECOVERY

- .11 The state department may seek to recover medical assistance expenditures correctly paid from the estates of deceased individuals as follows:
- A. Recoveries of payments are made for all medical assistance paid on behalf of an individual who was institutionalized at the time he/she received medical assistance
 - B. Recoveries of payments are made for nursing facility services, home and community-based services, and related hospital and prescription drug services paid on behalf of an individual who was 55 years of age or older at the time he/she received medical assistance. The state department does not make the optional recoveries described under federal law in 42 U.S.C. § 1396p(b)(1)(B)(ii) in the case of an individual described in this subsection.
- .12 The state department may limit estate recovery to recoveries that are cost-effective. The term "cost effective" means that the amount of medical assistance expenditures likely to be recovered is greater than the likely cost to the state of the recovery.
- .13 The state department may file a lien on the real property of an institutionalized person for the amount of medical assistance correctly paid on behalf of the person, only if:
- A. the department determines that the medical assistance recipient cannot reasonably be expected to be discharged from the institution and to return home; and
 - B. there is no spouse of the recipient lawfully residing in the home; and
 - C. there is no child of the recipient under age 21 or blind or disabled dependent of the recipient lawfully residing in the home; and
 - D. there is no sibling of the recipient who has an equity interest in the home and who was lawfully residing in the home for at least one year immediately prior to the date the recipient was admitted to the institution; and
 - E. later recovery from the estate is likely to be cost-effective.

Medical assistance payments made on behalf of an institutionalized recipient during the time that all lien criteria are not met will be subject to a lien at such time that all lien criteria are met.

- .14 The state department shall determine whether a medical assistance recipient reasonably can be expected to be discharged from the institution and to return home. This determination shall be made by the Utilization Review Contractor after notice and opportunity for a hearing. The determination that the recipient is not likely to return home will be used to decide if a lien will be filed. This determination will not change an exempt home into a countable resource for eligibility purposes.

The notice to the recipient shall include the following:

- A. A statement of the action that the Utilization Review Contractor intends to take, the reasons for the intended action, and the specific regulations that support the action.
- B. An explanation of the term "lien", and that imposing a lien does not mean that the individual will lose ownership of the home.
- C. A statement that the determination will not result in a loss of eligibility for medical assistance benefits.
- D. The process by which a recipient may request a hearing to appeal the decision of the Utilization Review Contractor.

The decision may be appealed through the procedures in the RECIPIENT APPEALS PROTOCOLS/PROCESS Section of this staff manual.

The state department shall dissolve any lien on a recipient's home if the recipient is discharged from the institution and returns to the home subject to the lien.

- .15 The state department shall not recover medical assistance expenditures correctly paid from the estate of a medical assistance recipient if:

- A. There is a surviving spouse of the recipient; or
- B. There is a child of the recipient under age 21 or a blind or disabled dependent of the recipient.

- 8.063.16 In addition to the prohibitions of 8.063.15, the state department shall not recover medical assistance expenditures correctly paid from the sale of the recipient's home, whether or not the home was subject to a lien, if:

- A. there is a sibling of the recipient who was lawfully residing in the home for at least one year immediately prior to the date the recipient was admitted to the institution and who has continuously lived in the home since that date; or
- B. there is a son or daughter of the recipient who was lawfully residing in the home for at least two years immediately prior to the date the recipient was admitted to the institution and who has continuously lived in the home since that date, and who provided care to the recipient which permitted the recipient to reside at home rather than in an institution.

If either of the two conditions above exist, the state department may recover medical assistance expenditures correctly paid from assets in the estate other than the sale of the recipient's home.

- .17 The state department shall file liens and recover expenditures for medical assistance provided on or after July 1, 1992.

- .18 The state department may compromise, settle, or waive recovery of medical assistance expenditures if it determines good cause to do so. The department shall determine that good cause exists if:
- A. it concludes that without receipt of the proceeds of the estate, the heirs would become eligible for assistance payments and/or medical assistance programs; or
 - B. it concludes that allowing the heirs to receive the inheritance from the estate will enable these individuals to discontinue eligibility for assistance payments and/or medical assistance programs; or
 - C. it concludes that the home is part of a business, including a working farm or ranch, and recovery of medical assistance expenditures will result in the heirs to the estate losing their means of livelihood.
- .19 The state department may agree to a payment plan for repayment of any debt owed the state under the Medical Assistance Estate Recovery Program.

8.064 DATA PROVISION AND CLAIMS REQUIREMENTS

8.064.1 DATA PROVISION FROM THIRD PARTIES

- 8.064.1.A. All third parties, as a condition of doing business in the state, shall provide on a monthly basis, and within 60 days of request, to the Department or its Business Associate or designee, including Medicaid MCO plans, an electronic file from the third party's database containing eligibility records of all persons covered by the third party containing the minimum necessary data elements to enable the Department or its Business Associate or designee to achieve a satisfactory data match. The Department or its Business Associate or designee has the right, in their sole discretion, to request additional data from any third party if the file provided does not result in a satisfactory data match that enables the Department or its Business Associate to determine which persons are dually eligible for medical assistance and the coverage provided by the third party necessary to prepare HIPAA compliant bills and for the purpose of cost avoidance. Such request will be cumulative and the third party will be required to submit monthly eligibility records with all requested data elements.
- 8.064.1.B Third parties are encouraged to work with the Department or its Business Associate or designee to enter into Data Use Agreements on a case by case basis. Execution of a Data Use Agreement with the Department or its Business Associate shall satisfy the Minimum Necessary requirement.
- 8.064.1.C. "Satisfactory Data Match" means obtaining results from the data match that enable the Department to achieve cost avoidance and that will provide medical providers with adequate information to bill the third party and have their claims adjudicated without request for further information from the third party and that enables the Department or its Business Associate or designee to bill previously paid claims to the third party resulting in proper adjudication without requests for further information from the third party to proceed with adjudication.
- 8.064.1.D. "Third Party" means a health insurer, self-insured plan, group health plan as defined in 29 U.S.C. Sec 1167(1), service benefit plan, managed care organization, pharmacy benefit manager, or other party, that is by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service, such as third party administrators.

- 8.064.1.E. "Minimum Necessary" is defined as those data elements necessary to achieve a satisfactory match, and includes, but is not limited to the following:
1. First name, Middle initial, and Last name;
 2. Date of Birth;
 3. Sex code (M or F);
 4. Social Security number or policy number if a crosswalk to actual social security numbers is provided contemporaneously, or the last 4 digits of the SSN;
 5. Policy and Group number;
 6. Group Name/Employer Name;
 7. Begin and end dates of coverage;
 8. Coverage types provided to each member and dependent;
 9. Pharmacy Indicator and PBM information including a crosswalk to PBMs if multiple PBMs;
 10. Subscriber Full address;
 11. Dependent(s) First name, Middle Initial, and Last name;
 12. Dependent(s) DOB;
 13. Dependent(s) SSN or last 4 digits of SSN;
 14. Dependent(s) Sex Code.
- 8.064.1.F. "Business Associate" shall have the same meaning as provided in 45 CFR 160.103.
- 8.064.1.G. Third parties shall accept and respond to inquiries and contact, either in writing or telephonically for verification purposes or otherwise, regarding members and coverage from the Department or its Business Associate or its designee including the provision of applicable NPI numbers.

8.064.2 CLAIMS REQUIREMENT

- 8.064.2.A. Third parties shall accept the Department's right of recovery and assignment of benefits from any individual or entity to the extent that such item or service is covered by the third party.
- 8.064.2.B. Claims shall not be denied for lack of preauthorization.
- 8.064.2.C. Claims shall not be denied for the type of format of the claim form.
- 8.064.2.D. Claims shall not be denied for a failure to present proper documentation at the point-of-sale that is the basis for the claim if the claim is presented within three years of the date that the item or service is furnished, and any action by the Department to enforce its right is commenced within six years after the Department's submission of the claim.

8.064.2.E. Third parties are required to accept and adjudicate claims submitted by the Department or its Business Associate and it is the duty of the third party to inform its clients that they intend to accept and adjudicate claims with or without specific authorization from its clients.

8.065 RECOVERY OF MEDICAL ASSISTANCE OVERPAYMENTS

8.065.1 For purposes of Section 8.065, an "overpayment" includes any medical assistance payments, including capitation payments, paid on behalf of a recipient who was not lawfully entitled to receive the benefits for which the payments were made. The County Department of Social Services shall recover all overpayments except that no recovery shall be made where the overpayment occurred through no fault of the recipient.

8.065.2 RECOVERY PROCESS

- .21 When it is determined that an overpayment has occurred, the county department shall within 90 days:
- A. Document the facts and circumstances which produced the overpayment and retain this documentation until the overpayment is paid in full or otherwise resolved.
 - B. Initiate timely and adequate notice as set forth in Section 8.057, ADVANCE NOTICE, of this Staff Manual. Such notice shall include applicable rules concerning the overpayment and recovery sought, and shall request the client to voluntarily repay the amount overpaid.
 - C. Pursue all legal remedies in order to recover the overpayment following the 10-day advance notice period and appeal, if any, pursuant to 8.058, RECIPIENT APPEALS PROTOCOLS/PROCESS of this Staff Manual. Legal remedies include, but are not limited to, judgments, garnishments, claims on estates, interception of other grants in aid, and the State Income Tax Refund Intercept process.
- .22 In accordance with Sections 26-2-133 et seq., C.R.S., the state and county departments may recover overpayments of medical service benefits through the offset (intercept) of a taxpayer's state income tax refund. This method may be used to recover overpayments which have been:
- A. determined by final agency action, or
 - B. ordered by a court as restitution, or
 - C. reduced to judgment.
- .23 Prior to certifying the taxpayer's name and other information to the Department of Revenue, the county department shall notify the taxpayer, in writing at his/her last-known address, that the State intends to use the tax refund offset to recover the overpayment. The pre-offset notice shall include the name of the county department claiming the overpayment, a reference to Medicaid as the source of the overpayment, and the current balance owed.
- .24 The taxpayer is entitled to object to the offset by filing a request for a county evidentiary conference or state hearing within 30 days from the date that the county department mails its pre-offset notice to the taxpayer. In all other respects, the procedures applicable to such hearings shall be those which are stated in this Staff Manual (Section 8.057). At the hearing on the offset, the county department or Administrative Law Judge shall not consider whether an overpayment has occurred, but may consider the following issues if raised by the taxpayer in his/her request for a hearing:

- A. Whether the taxpayer was properly notified of the overpayment.
- B. Whether the taxpayer is the person who owes the overpayment.
- C. If the amount of the overpayment has been paid or,
- D. If the offset amount is incorrect, or
- E. If the debt created by the overpayment has been discharged through bankruptcy.

8.066 HEALTH INSURANCE BUY-IN

The purpose of the Department of Health Care Policy & Financing (Department)'s Health Insurance Buy-In (HIBI) program is to reduce, or shift, Medicaid liability by paying the cost of private health insurance premiums and out-of-pocket expenses for Medicaid clients, when it is cost-effective for Medicaid to do so. The health insurance premiums, deductibles, coinsurance, or other cost-sharing obligation for services, of Medicaid clients who are enrolled in a group or individual health insurance plan, will be paid by the Department, when it is cost-effective to do so. Payment of said services shall be treated as payment for medical assistance. This program is in addition to a client's regular Medicaid benefits.

.1 ELIGIBILITY/CONDITIONS FOR ENROLLMENT

.11 In order to be eligible to participate in the HIBI program, the following criteria must be met:

- A. Client must be eligible for Medicaid during the time period for which premium or cost-sharing payment is requested.
- B. Client must be covered by, or have access to, a cost-effective group or individual health insurance plan.
- C. Client must comply with the requirements of their health insurance plan.
- D. Client must provide documentation required by the Department, sufficient to verify eligibility, continuing coverage, and to permit accurate reimbursement.

.12 Once shown to be cost-effective, enrollment in a group or individual health insurance plan shall be required of clients as a condition of obtaining or retaining Medicaid. A client who is a policyholder shall be required to enroll his or her dependents in the insurance plan, if the dependents are Medicaid-eligible and also eligible to enroll in the cost-effective health insurance plan. However, Medicaid for such dependents shall not be discontinued if a policyholder fails to enroll the Medicaid-eligible dependent.

8.066.2 COST-EFFECTIVENESS

- .21 The determination of cost-effectiveness shall be in accordance with applicable state and federal guidelines.
- .22 A Medicaid client's enrollment in a group or individual health plan is cost-effective when the amount paid for premiums and other cost-sharing obligations plus the State's administrative costs are less than Medicaid's expenditure for an equivalent set of services for the average person in the same category of service.
- .23 If a plan is determined not to be cost-effective using average Medicaid costs in the above process, the specific client's known historical medical costs may be substituted for the average Medicaid costs in the above formula.

- .24 If a Medicaid client has access to more than one health insurance plan, a cost-effectiveness evaluation shall be performed on each. The client shall be informed as to which plan(s), if any, are likely to be cost-effective to Medicaid. The Medicaid client shall be required to enroll in the health plan that indicates the greatest cost savings to Medicaid. If multiple health plans are equally cost-effective, the client may choose which plan to enroll in.
- .25 Written notification shall be mailed to the Medicaid client upon approval for participation in HIBI. The notification will include the effective date, participation requirements, and applicable instructions.
- .26 The enrollment in, or continuation of, a health insurance plan determined not to be cost-effective shall be the client's decision. The client shall be required to notify the county of any plan change or termination. The disposition of such non-cost-effective health insurance plan shall not affect a client's Medicaid eligibility.

8.066.3 PAYMENT OF PREMIUMS

- .31 Premiums and cost-sharing will be paid by the Department, from the date the Department receives a premium claim or an approved referral.
 - A. Up to three (3) months of premium back-payments will only be considered in the following circumstances:
 - (1) Consolidated Omnibus Budget Reconciliation Act (COBRA) invoice, which may cover one to three months.
 - (2) The first invoice of any new plan, which may cover more than one month.
 - (3) Reinstatement of an insurance plan in arrears, if shown to be cost-effective to Medicaid.
 - (4) In certain cases, if it is cost-effective to Medicaid, and good cause is shown. The term "good cause" is defined as conditions outside the control of the individual such as, but not limited to, sudden illness, fire, theft, or acts of God.
 - B. For pregnant women, premiums will be paid by the Department through the end of the month following the birth of the baby.
- .32 Premium payment will be made to an insurance carrier, employer, COBRA administrator, or directly to the client or policyholder, if circumstances warrant.
- .33 Only the portion of the premium that covers the Medicaid client will be paid (i.e., the amount the policyholder would save if he/she were to drop the Medicaid client from coverage). This amount shall be obtained from the premium cost breakdown supplied by the employer or insurance company.
- .34 The portion of the premium covering plan members who are not Medicaid-eligible will be paid if paying the full premium amount is necessary to obtain coverage for the Medicaid-eligible client(s).
- .35 If payment is made in error, the Department has the right to recover the funds paid in error. If a Medicaid client fails to return monies received, participation in the HIBI program may terminate, and the client's county technician may be notified of undeclared income, which may jeopardize Medicaid eligibility.

8.066.4 CRITERIA FOR EXCLUSION

- .41 Criteria for exclusion from the HIBI program are as follows:
- A. Medicaid payment of the client's health insurance premium is not found to be cost-effective.
 - B. Client is no longer eligible for Medicaid.
 - C. Eligibility for, or access to, the health insurance plan has ended.
 - D. Payment of the Medicaid client's health insurance premium cannot be made because the insurance coverage is a court-ordered obligation.
 - E. Health Insurance is provided at no cost to either the client or policyholder.
 - F. Policyholder intends to continue premium payment and does not want to participate in HIBI.
 - G. Client has not provided documentation required by the Department.
 - H. Client does not comply with the requirements of their health insurance plan.
- .42 Written notification of denial or discontinuation shall be mailed to the Medicaid client upon determination that the Medicaid client is not eligible for participation in the HIBI program. The notification will include the effective date and reason for denial or discontinuation.

.5 USE OF/NON-MEDICAID PROVIDERS

The Medicaid client can continue to use his/her own medical provider that participates in the cost-effective health insurance plan. If the provider is not an approved Medicaid provider, the cost of deductibles, coinsurance, and other cost-sharing amounts will be paid by the Department, if it would still be cost-effective to do so.

.6 CLIENT APPEAL RIGHTS

If a Medicaid client is denied or discontinued from participation in the HIBI program, he/she may appeal the decision to the Department of Health Care Policy and Financing. The aggrieved Medicaid client shall file his or her written appeal within sixty (60) days of the mailing date of the adverse action to the HIBI program, the Department of Health Care Policy & Financing. The written appeal will be reviewed by the HIBI officer and manager. A written response to the appeal will be sent to the appellant within 60 calendar days of receipt of the written appeal. A cost-effectiveness evaluation may be resubmitted to the Department with additional information for consideration. Denial or discontinuation at one point in time does not preclude future participation.

8.070 MISUTILIZATION, FRAUD, OR ABUSE

8.070.01 ACTIONS CONCERNING INDIVIDUALS SUSPECTED OF FRAUDULENT ACTS

It is the duty of the county department to take action against any person suspected of obtaining Medicaid benefits to which he is not entitled or in a greater amount than that to which he is entitled.

* Much of Section 8.070 was eliminated and Section 8.076 was created and adopted by the Medical Services Board on December 8, 2000.

8.075 CLIENT OVERUTILIZATION PROGRAM

8.075.1 Authority is given in 42 CFR 456.3 and 431.54(e) to establish a process that safeguards against unnecessary or inappropriate utilization of care and services. This program allows for the development and review of client utilization profiles, provider service profiles and exception criteria. It identifies excessive patterns in order to rectify overutilization practices of clients, providers and institutions.

8.075.2 The Client Overutilization Program restricts Medicaid clients to one designated pharmacy, primary care physician (PCP) or managed care organization (MCO) when there is documented evidence of abuse or overutilization of benefits.

8.075.3 DEFINITIONS

Client Overutilization Program means a process used to restrict a Medicaid client to a single physician or managed care organization and a single pharmacy to control excessive Medicaid benefits usage.

Overutilization means the improper or excessive utilization of medical care and services that are not medically necessary.

8.075.4 Clients whose utilization of Medicaid benefits without medical necessity has exceeded any one of the following parameters during a quarter shall be subject to placement in the program:

1. Use of three or more drugs in the same therapeutic category;.
2. Use of three or more pharmacies;
3. Use of sixteen or more prescriptions; or
4. By referral, review or other analysis that indicates possible overutilization.

8.075.4.A. Once the Department identifies a client that falls under 8.075.4, a post-payment review of documented information may be initiated, which includes but is not limited to:

1. Medicaid Management Information System reports;
2. Billing invoices;
3. Investigative reports;
4. Medical record reviews.

8.075.4.B. The Department shall inform the client in writing of program placement. The client will be notified of client's appeal rights granted in accordance with 8.057. The client will not be placed in the Overutilization Program until the appeal has been heard and a decision rendered or if no appeal, the appeal timeline has passed. The client has 10 days from the date the notification is mailed to appeal the decision.

8.075.4.C. The client will work in conjunction with the Department to select one physician or managed care organization and one pharmacy in which to receive their care. Clients shall be in the Client Overutilization Program for at least 12 consecutive months.

8.075.4.D. If a client becomes ineligible for Medicaid benefits during the restricted period, restrictions shall automatically commence for 12 consecutive months from the month eligibility is reestablished unless determined otherwise by the Department.

8.075.4.E. The following shall apply when the client has been assigned to the selected physician/MCO and pharmacy:

1. The client shall receive notification that identifies the program restrictions and providers. It is the responsibility of the client to request services only from the providers identified on the card. Emergency services are available to the client without the need to prior authorize the services.
2. The client shall have the right to a second surgical opinion should surgery be deemed necessary by the designated physician.

8.075.4.F. The designated provider shall serve as the case manager for the client. The physician shall authorize and monitor services rendered to the client by any other provider.

8.075.4.G. A change in designated providers may be granted if any of the following occur:

1. The provider moves, retires, dies, discontinues Medicaid participation or refuses to continue providing care to the client; or
2. The client moves from the physician's service area.

8.075.4.H. Restrictions will be rescinded upon the written recommendations of the client's designated provider and the Department. The Department will notify the client in writing of the decision to rescind restrictions. If, after the case review the decision is not to rescind the restrictions the client shall be afforded the opportunity to appeal in accordance with 8057.

8.075.5 CLIENT REFUSAL TO COOPERATE

8.075.5.A. If the client refuses to cooperate with the Department and does not appeal the decision to be placed in the program, the Department shall proceed with program placement. The Department shall notify the client of the providers and the effective date of implementation.

8.076 PROGRAM INTEGRITY

8.076.1 DEFINITIONS

1. Abuse means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medical Assistance program, an Overpayment by the Medical Assistance program, in reimbursement for goods or services that are not medically necessary, as defined at Section 8.076.1.8., or that fail to meet professionally recognized standards for health care. These practices may include, but are not limited to:
 - a. Billing for goods or services without valid documentation to support the claims submitted for reimbursement.
 - b. Unbundling charges on claims for goods or services by separating components of a group of procedures that are required to be billed together (or bundled), and billing each component separately.

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- c. Submitting a fee-for-service claim or claims for goods or services before they have been provided.
 - d. Signing prior authorizations or physician's orders for goods or services that are inappropriate or not medically necessary for the client.
 - e. Presenting or causing to be presented for payment any false or fraudulent claim for goods or services.
 - f. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.
 - g. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.
 - h. Failing to retain or disclose or make available to the Department or its authorized agent(s) records of goods or services provided to eligible clients and related records of payments when requested.
 - i. Engaging in a course of conduct or performing an act deemed improper or continuing such conduct following notification that said conduct should cease.
 - j. Visiting a facility, such as a nursing home, and billing for individual visits without rendering any specific service to individual clients.
 - k. Overutilizing by inducing, furnishing, or otherwise causing a client to receive goods or services not otherwise required or requested by the client or prescribing Provider.
 - l. Violating any applicable regulation listed at Section 8.000, et seq. or failing to comply with any guidance provided by the Department, including but not limited to provider bulletins and billing manuals.
 - m. Submitting a false or fraudulent application for provider enrollment.
 - n. Violating any laws or regulations pertaining to federal or state health care programs or failing to meet professionally recognized standards for health care.
 - o. Conviction of a criminal offense relating to:
 - i) Performance of the Provider Agreement with the State;
 - ii) Negligent practice resulting in the death or injury to patients;
 - iii) Patient abuse;
 - iv) Fraudulent billing practices;
 - v) Misuse or misapplication of program funds;
 - vi) The unlawful manufacture, distribution, prescription or dispensing of controlled substances; or
 - vii) Actions that indicates a Provider may pose a risk to the health, safety, or well-being of a client.
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- p. Failure to meet standards required by state or federal law for participation such as licensure or certification requirements.
 - q. Failure to correct deficiencies in provider operations in accordance with an accepted plan of correction or written response after receiving written notice of these deficiencies from the Department, its designees, or other state agencies.
 - r. Formal reprimand or censure by an association of the Provider's peers or the appropriate state or federal regulatory or licensing body for unethical, illegal, or improper practices.
 - s. Suspension, exclusion, or termination from participation in another governmental medical program for fraudulent or abusive practices.
 - t. Failure to repay or make arrangements to repay Overpayments or payments made in error.
 - u. Use of another Provider's provider identification number for the purpose of obtaining reimbursement.
 - v. Use of client identification numbers to submit claims for reimbursement for goods or services that were not rendered or delivered.
 - w. Alteration of any source documentation performed to support claims billed or creation of new source documentation to support claims billed when the alteration or creation occurs after a request for documentation is received by the Provider from the Department or its agent. Alteration does not include a late entry that is signed and dated when documented or transcriptions made to facilitate a Department review.
 - x. Upcoding services by submitting claims for a higher level of goods or services than what was provided or medically necessary.
2. Conviction or Convicted means that:
- a. A judgment of conviction has been entered against an individual or an entity by a federal, state, or local court, regardless of whether there is a post-trial motion or an appeal pending;
 - b. A federal, state, or local court has made a finding of guilt against an individual or entity;
 - c. A federal, state, or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
 - d. An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.
3. Excluded means a Provider that has been barred from participating in any health care program by the Office of Inspector General for the United States Department of Health and Human Services (OIG).

4. False Representation means an inaccurate statement that is relevant to a claim for reimbursement or Prior Authorization Request and is made by a Provider who has actual knowledge of the truth or false nature of the statement, or by a Provider acting in deliberate ignorance of or with reckless disregard for the truth of the statement. A Provider acts with deliberate ignorance of or with reckless disregard for the truth if the Provider fails to maintain records required by the Department or if the Provider fails to become familiar with rules, manuals, and bulletins issued by the Department, board or the Department's fiscal agent.
5. Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to her/himself or some other person. It includes any act that constitutes fraud under any federal or state law.
6. Furnished means goods or services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a Provider, or other supplier of goods or services.
7. Good cause, for the purpose of withholding payments to a provider or denying, terminating, or not renewing a Provider agreement means:
 - a. The Provider has failed to comply substantially with rules, manuals, and bulletins issued by the Department, board, or the Department's fiscal agent.
 - b. The Provider has not complied with applicable federal and state statutes and regulations.
 - c. The Provider, either by omission or commission, is endangering or has endangered the health, safety, or well-being of a program services client or clients.
 - d. The owner, operator, partner, or other participating employee of the Provider has previously owned, operated, or otherwise participated in and received direct or indirect payment from the Medical Assistance Program and has a documented pattern of program abuse, substandard care, endangerment of the health or well-being of clients, or non-compliance with program requirements.
 - e. The Provider's license or certification has expired, been revoked, suspended, surrendered while a formal disciplinary proceeding was pending before a state licensing authority, or for any other reason is invalid at the time goods are provided or services are rendered for which claims are submitted for reimbursement.
 - f. The Provider has been excluded, suspended, or terminated from any Medical Assistance program of another state or has been excluded, suspended, terminated or had had its billing privileges revoked under the Medicare program, or has been excluded by the OIG unless a waiver is granted by the OIG.
 - g. The Provider has failed to fully and accurately make any disclosures required by federal and state statutes or regulations.
 - h. Any Provider, or person with an ownership or controlling interest in the Provider, or who is a Provider's agent or managing employee, has been convicted of a criminal offense outlined in Section 8.076.1.1.o.

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- i. The Provider has demonstrated a pattern of Abuse.
 - j. The Provider has engaged in False Representation and/or Fraud in submitting Medical Assistance program claims.
 - k. The Provider has billed or sought collection through a third party from a client or the estate of a client, his or her family, friend, or other representative, for any amount for covered goods or services, excluding any required copayment, coinsurance, or other client cost-sharing amounts, and failed, once notified by the Department, to correct the billing or collection action.
 - l. The Provider has failed to return money paid by clients for covered goods or services rendered during any period of client eligibility. This includes failing to pay back clients for goods or services for which they were charged when their eligibility was determined retroactively and there is evidence of notification of retroactive eligibility for the client, regardless of whether payment for the covered goods or services were received.
 - m. The Provider owes the Department an outstanding balance and has failed to enter into a payment plan with the Department or the provider has failed to comply with a payment plan it had previously entered into.
 - n. The Provider has failed to provide a written response within thirty (30) days of the Department's request or the Provider has provided a written response but failed to meet the requirements set out in the Department's request as described in Section 8.076.6.
 - o. The Provider has failed to provide information related to the False Claims Act and whistleblower protections described in Section 8.076.7, within thirty (30) days of the Department's request.
8. Medical necessity means a Medical Assistance program good or service:
- a. 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, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all;
 - b. Is provided in accordance with generally accepted professional standards for health care in the United States;
 - c. Is clinically appropriate in terms of type, frequency, extent, site, and duration;
 - d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;
 - e. Is delivered in the most appropriate setting(s) required by the client's condition;
 - f. Is not experimental or investigational; and
 - g. Is not more costly than other equally effective treatment options.

9. Overpayment means the amount paid to a Provider which is in excess of the amount that is allowable for goods or services furnished and which is required by Title XIX of the Social Security Act to be refunded. An Overpayment may include, but is not limited to, improper payments made as the result of fraud, waste, and abuse.
10. Provider means any person, public or private institution, agency, or business concern enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods.

8.076.2 COMPLIANCE MONITORING

8.076.2.A. All Providers shall comply with the efforts of the Department, the U.S. Department of Health and Human Services (HHS), any investigative entity, the Medicaid Fraud Control Unit (MFCU), or their designees to monitor Provider compliance with federal and state Medical Assistance program statutes, regulations and guidance in order to detect and correct noncompliance and prevent fraud, waste and abuse.

8.076.2.B. Compliance monitoring includes, but is not limited to:

1. Conducting prospective, concurrent, and/or post-payment reviews of claims.
2. Verifying Provider adherence to professional licensing and certification requirements.
3. Reviewing goods provided and services rendered for fraud, waste and abuse.
4. Reviewing compliance with rules, manuals, and bulletins issued by the Department, board, or the Department's fiscal agent.
5. Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT), Current Dental Terminology (CDT), and Healthcare Common Procedure Coding System (HCPCS).
6. Reviewing adherence to the terms of the Provider Participation Agreement.

8.076.2.C. Compliance monitoring activities may include, but are not limited to:

1. Site reviews.
2. Desk audits.
3. Medical records reviews.
4. Claims reviews.
5. Data mining.

8.076.2.D. The Department, HHS, investigative entities, the MFCU, or their designees has the right to audit and confirm any information submitted by the Provider to the Medical Assistance program. The Provider shall furnish information about submitted claims, claim documentation records, and original source documentation including, but not limited to, provider and patient signatures; medical, accounting, or financial records; or any other relevant information upon request.

8.076.2.E. A written request to review records shall be provided to the Provider. This request shall include clearly defined due dates for submitting requested records, and the procedures for requesting an extension of time to submit the requested records. This request shall include the option of providing paper copies of records, electronic copies of records in a format that is compatible with the Department's or its designee's systems, or an inspection or reproduction of the records by the Department or its designees at the Provider's site. Medical records requested for review shall be provided to the Department at the expense of the Provider. The Provider shall submit or produce the requested materials within forty-five (45) calendar days unless:

1. The review is based on quality of care concerns, in which case the materials shall be submitted within fourteen (14) calendar days of the request;
2. The request is made during the course of a civil or criminal investigation, in which case the records shall be submitted immediately upon request; or
3. The request is made during the course of an external audit with the state or federal government, in which case the records shall be submitted within the timeframe the external auditors request.

8.076.2.F. Records received by the Department after the forty-five (45) calendar day deadline may be considered in the review at the Department's discretion. The written request for an extension to submit records must be received by the Department within fifteen (15) calendar days from the date of the Department's request. Telephone requests shall not be accepted. The request shall specify the additional time requested and the circumstances present that require an extension of time.

8.076.2.G. Any claims submitted for which documentation is not received within the time limits specified in this section shall be considered an Overpayment subject to recovery regardless of whether goods or services have been provided.

8.076.2.H. A Provider subject to a review or audit may request an interview in person or by telephone with the Department or its designees before the final written post-review correspondence is released. The request for an interview must be in writing, specify whether an in person or telephone interview is being requested, and must be received by the Department within ten (10) calendar days from the date of the Department's request for records. During this interview, the Provider may discuss the preliminary findings of the review or audit, what documentation the Provider may use to refute the findings, and the next steps in the review or audit process.

8.076.2.I. For all post-payment reviews, the Provider shall receive a letter identifying the Overpayment demand or notice of no repayments. This notice shall include the procedures for requesting an informal reconsideration or an appeal.

8.076.2.J. The staff of the Department, HHS, investigative entities, the MFCU, or their designees may photocopy or otherwise duplicate any paper or electronic document, chart, policy, or other record relating to medical care or services provided, charges to or payments made by clients, or goods or services provided for which a claim is submitted. The use of duplicating equipment on the Provider's premises shall be allowed to the extent that such use results in minimal disruption of the Provider's business. If such use of duplicating equipment will cause more than minimal disruption of business, the Provider shall notify the Department in writing or by telephone, and the Department shall attempt to resolve the issue with the Provider or make other arrangements.

8.076.2.K. Providers who maintain records to substantiate their claims for reimbursement in another entity's records including, but not limited to, a nursing facility, adult day care center, or hospital, are still subject to the requirements set forth at Section 8.076.2.E.

8.076.2.L. The Department may delegate compliance monitoring activities to its designees.

8.076.2.M. Nothing in Section 8.076 shall be construed as limiting the right of the Department to conduct quality improvement activities in accordance with the provisions of Section 8.079.

8.076.2.N. Nothing in Section 8.076 shall be construed as limiting the right of the Department to conduct emergency site visits when the Department has concerns about client safety, quality of care, fraud, abuse, or Provider financial failure.

8.076.3 RECOVERY OF OVERPAYMENTS

8.076.3.A. Overpayments are subject to recovery by the Department or its designees.

8.076.3.B. Any identified Overpayment shall be recoverable from the Provider following exhaustion of any informal reconsideration and appeal pursuant to 8.050.

1. Overpayments and/or other indebtedness to the state are recoverable through a repayment agreement with the Provider, by offsetting the amount owed against current and future claims of the Provider, through litigation, or by any other appropriate action within the Department's legal authority.
2. The offset rate shall be 100% of the total amount owed to be withheld from subsequent payments until the entire amount owed is recovered. The Overpayment offset rate may be reduced if the Provider shows good cause that withholding payment at the established rate will result in undue hardship.
3. In cases where sufficient records are not available to the reviewer or auditor, the recovery may be determined through a sampling of records so long as the sampling and any extrapolation are reasonably valid from a statistical standpoint and is in accordance with generally accepted auditing standards.

8.076.3.C. Self-Disclosure of Provider Identified Overpayments

1. If a Provider has received an Overpayment, the Provider is required to report and return the Overpayment within sixty (60) days of identification.
2. Identification of an Overpayment occurs when the Provider has determined that it has received an Overpayment and quantified the amount of the Overpayment.
3. Reporting an Overpayment must be made in writing and at a minimum contain the following information:
 - a) Provider National Provider Identification (NPI);
 - b) Provider Medicaid Identification Number;
 - c) Provider contact information (name, phone number, address and email address);
 - d) Claims affected for each service location; and
 - e) Basis for the Overpayment determination.
4. Failure to report and return the Overpayment within sixty (60) days of identification shall result in the Department recovering the Overpayment plus statutory interest in accordance with Section 8.076.3.C.

5. Self-disclosure of Provider-identified Overpayments are not an Adverse Action as defined in Section 8.050, and are not subject to an appeal.

8.076.4 SUSPENSION OF PAYMENTS IN CASES OF A CREDIBLE ALLEGATION OF FRAUD

8.076.4.A. Payments to a Provider will be suspended, in whole or in part, upon a determination of a credible allegation of fraud for which an investigation is pending unless there is good cause to not suspend payments or to suspend payment only in part.

1. An allegation of fraud is considered credible if the allegation has evidence of reliability after a review of the allegation, facts and evidence.
2. A determination that there is good cause to not suspend payments or to suspend payment only in part will be made in accordance with the provisions in 42 C.F.R. § 455.23(e)-(f).

8.076.4.B. A Provider shall be notified of a suspension of payments, in whole or in part, by a notice of Adverse Action.

8.076.4.C. A Provider shall be granted appeal rights in accordance with Section 8.050.

8.076.4.D. Payments may be suspended without first notifying the Provider of the intention to withhold such payments. Notice of suspension of payments shall be sent to the Provider within the following timeframes:

1. Within five (5) calendar days of taking such action.
2. Within thirty (30) days if requested by law enforcement in writing to delay sending the notice. Requests for delay notice may be renewed in writing twice, not to exceed ninety (90) days.

8.076.4.E. The notice shall include:

1. A statement that payments are being suspended in accordance with this provision and 42 C.F.R. § 455.23;
2. The general allegations as to the nature of the suspension of payments action;
3. A statement that the suspension of payments is for a temporary period, and the circumstances under which suspension of payments will be terminated;
4. Which type or types of claims are subject to the suspension of payments, when appropriate;
5. A statement that the Provider may submit written evidence showing why the suspension of payments should not be implemented for consideration by the Department; and
6. The right to appeal as described in Section 8.050.

8.076.4.F. A suspension of payment action under Section 8.076.4 shall cease if the Department or prosecuting authorities determine that there is insufficient evidence of fraud or false representation by the Provider or if legal proceedings related to the alleged fraud are complete.

8.076.5 DENIAL, TERMINATION AND/OR NONRENEWAL OF PROVIDER AGREEMENTS

8.076.5.A. The Department may deny an application for a Provider agreement, terminate or not renew a Provider agreement for Good Cause, as defined at Section 8.076.1.7.

8.076.5.B. A potential Provider shall be notified of the Department's decision to deny an application for a Provider agreement by a notice of Adverse Action.

8.076.5.C. A Provider shall be notified of the Department's decision to terminate or not renew a Provider agreement by a notice of Adverse Action. Termination and/or nonrenewal shall not be effective sooner than thirty (30) calendar days from the date of the notice except as provided at Section 8.076.5.D, where notice will be provided within five (5) calendar days of taking such action.

8.076.5.D. Provider agreements may be terminated without prior notice if:

1. The Provider has been convicted of fraud or convicted of a crime related to the Provider's involvement in Medicare, Medicaid, or any other federally funded program;
2. The Provider has been found to have made a false representation;
3. The termination is imperatively necessary for the preservation of the public health, safety, or welfare and observance of the requirements of notice would be contrary to the public interest. Within five (5) business days of the emergency termination, the Provider shall receive a notice of Adverse Action;
4. The Provider has been excluded by the OIG, or Medicare has terminated its Provider agreement or revoked the Provider's billing privileges.

8.076.5.E. Providers who had their Provider agreement terminated for Good Cause under this Section must apply for reinstatement in the Medical Assistance program prior to filing an application for enrollment. In order to apply for reinstatement, the Provider-applicant must send a written request to the Department that includes information that provides reasonable assurances that the actions that were the basis for termination have not reoccurred and will not recur in the future. After reviewing the written request, the Department will notify the provider of whether the provider is eligible for reinstatement or if the reinstatement has been denied, If the reinstatement has been denied the provider has the right to appeal in accordance with Section 8.050.

8.076.6 REQUEST FOR WRITTEN RESPONSE

8.076.6.A. The Department may request a written response from any Provider who fails to comply with the rules, manuals, bulletins, other guidance issued by the Department, state board or the Department's fiscal agent, or from any Provider whose activities endanger the health, safety, or welfare of clients.

1. The request by the Department will be made in writing and contain specific information on the Provider's failed compliance.
2. The Provider must provide a written response within thirty (30) calendar days of the request addressing each identified area of failed compliance and either describe how the Provider will come into and ensure future compliance, or provide an explanation and specific reason why the Provider disagrees with the Department's finding of failed compliance.

3. The Department will review the written response to determine if it addresses the identified areas of failed compliance or provides an acceptable explanation of why the Department's findings were incorrect. The Department will notify the Provider of its determination within thirty (30) calendar days of the receipt of the response.

8.076.6.B Once the Department has requested a written response, the Department may take the following actions until it determines that the Provider has come into compliance:

1. Conduct a prospective review to ensure compliance with rules in accordance with Section 8.076.2.
2. Prohibit the provider from accepting new referrals or receiving reimbursement for services provided under new referrals for Medicaid services.

8.076.7 FALSE CLAIMS ACT AND WHISTLEBLOWER PROTECTIONS COMPLIANCE

8.076.7.A. If an entity is reimbursed at least \$5,000,000 per year, as a condition of reimbursement the entity must maintain documentation:

1. Establishing written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established 31 U.S.C. §§ 3729-3733; administrative remedies for false claims and statements as provided in 31 U.S.C. §§ 3801-3812; state laws pertaining to civil or criminal penalties for false claims and statements; and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse;
2. Detailing provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
3. Of the employee handbook for the entity, including a specific discussion of the laws described in subparagraph (1), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

8.076.7.B. In order to ensure compliance with the provisions of Section 8.076.7.A, the entity must comply with written requests for this information within thirty (30) calendar days.

8.079 QUALITY IMPROVEMENT

8.079.1 DEFINITIONS

Incentive payment means an annual payment made to PIHP contractors based on performance measures agreed upon by the Department and the contracted entity. The criteria for the incentive payment must meet all state and federal statutes and regulations.

Managed Care Entity means, for purposes of Section 8.079, any person, public or private institution, agency or business concern with which the Department does business pursuant to a capitated reimbursement contract.

Prepaid inpatient health plan (PIHP) means an entity that- (1) Provides medical services to enrollees 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; (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.

Provider means a Provider, as defined in 8.050.1.4.

8.079.2 EXTERNAL QUALITY REVIEW (EQR)

Providers and Managed Care Entities shall comply with annual EQR activities. EQR may include, but is not limited to the following activities:

1. Performance improvement projects.
2. Performance improvement project validation.
3. Performance improvement measurement.
4. Performance improvement measurement validation.
5. Consumer satisfaction survey.
6. Medical record review.
7. Review of individual cases.
8. PCPP credentialing and recredentialing.

8.079.3 MONITORING AND REVIEW

8.079.3.A. All Providers and Managed Care Entities shall comply with the efforts of the Department, its designees, any investigative entity, or the Medicaid Fraud Control Unit to monitor performance through site visits, reviews, desk audits, emergency site visits, profiling, compliance reporting requirements and other quality and program integrity review activities. Monitoring activities shall be conducted for the purpose of determining compliance with state and federal requirements, contracts or Provider agreements, Medicaid service provision and billing procedures, and/or Medicaid Bulletins and Provider Manuals.

1. Managed Care Entities - The Managed Care Entity shall be subject to annual site visits to determine compliance with established standards. The annual site visit process shall consist of a desk audit component and an onsite visit. The Managed Care Entities and/or its subcontractors shall, upon request, provide and make available staff to assist in the audit or inspection efforts and provide adequate space on the premises to reasonably accommodate review personnel.
2. Providers – Providers shall be subject to the compliance monitoring provisions of 8.076.2.
3. The Department reserves the right to deem other State agencies or private accreditation organizations approved reviews to constitute compliance with specific contractual obligations or regulatory requirements.
4. The Department may delegate monitoring activities.
5. The Department may conduct emergency site visits when the Department has concerns about patient safety, quality of medical care, fraud, abuse, or Provider financial failure.

8.079.4 QUALITY BASED INCENTIVE PAYMENTS FOR PIHP CONTRACTS

Performance measures eligible for incentive payment may include but are not limited to measures of quality and effectiveness of care, including process and outcomes; client satisfaction; use of services; and care outcomes; with the intent to provide incentive for delivering the highest quality care with the best outcomes at the best value for Colorado Medicaid clients enrolled in PIHP-contracted managed care plans. Measures shall be credible, comparable and actionable for the purpose of the incentive program.

8.079.4.A Such performance measures may include but are not limited to:

1. Healthcare Effectiveness Data and Information Set (HEDIS) measures;
2. Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures;
3. In-patient hospitalizations for ambulatory sensitive conditions such as: urinary tract infections, immunization preventable disease in pediatric clients, asthma, etc.
4. Hospital readmissions within 7, 30 and 90 days post-discharge;
5. Behavioral Health Organizations' penetration rates for both children and adults by region;
6. Statewide Behavioral Health Organization measures;
7. Other measures related to quality of care, use of services and care outcomes.

8.079.4.B. Additionally, incentive payments may be made to PIHPs to provide for an increase in the fee paid to the contractor in an reasonable amount calculated to cover the costs of collecting, maintaining and coordinating medical records of recipients among rendering providers through an electronic medical records health information exchange system, provided that the system meets all applicable state and federal statutes and regulations, and is used to measure and enhance the quality of care and care outcomes in accordance with the criteria listed in this rule for the Medicaid clients served.

8.079.4.C. In order to be eligible for any incentive payments, PIHP contractors must meet minimum performance measure criteria determined by the Department. Minimum performance criteria shall include minimum national percentile benchmarks for specific measures, and/or alternate minimum standards for non-HEDIS measures, as determined by the Department and agreed upon by the contractor at the outset of the contract period.

8.079.4.D. Performance measures and minimum performance criteria shall be agreed upon at the outset of the contract period and may vary from PIHP agreement to PIHP agreement at the discretion of the Department to reflect differences in contract type or model (e.g., BHO vs. Health Plan, network vs. group/staff system, risk vs. non-risk), as well as targeted performance improvement or maintenance objectives.

8.079.4.E. Provision of any incentive payment is contingent upon the continuing availability of state funds for the purpose thereof.

8.080 MEDICAID ELIGIBILITY QUALITY CONTROL

- 8.080.1 County departments of social/human services and other Department-designated eligibility sites shall maintain, store and preserve electronic and physical individual Medicaid case record(s) and other client-related confidential material to permit the Department to periodically evaluate the accuracy of Medicaid eligibility determinations. Medicaid case records are the property of the Department and shall be restricted to use by the state and county departments of social/human services and other Department-designated eligibility sites.
- 8.080.2 County departments of social/human services and other Department-designated eligibility sites shall provide records to the Department within ten (10) working days of request.
- 8.080.3 County departments of social/human services and other Department-designated eligibility sites shall respond to the eligibility review findings by completing the Department-prescribed MEQC response form documenting the corrective action taken. The response shall be forwarded to the Department within ten (10) working days from the date of the review finding notification.
- 8.080.4 To be considered by the Department, requests from county departments of social/human services and Department-designated eligibility sites for specific program policy interpretation relevant to MEQC pilot projects shall be received by the Department within ten (10) days of the MEQC review findings. All program policy decisions are final.
- 8.080.5 County departments of social/human services and Department-designated eligibility sites shall make electronic or physical records available for on-site reviews as requested.

8.090 MEDICAID CLAIMS PROCESSING AND THIRD PARTY LIABILITY QUALITY CONTROL

8.091 PURPOSE

- .10 Medicaid Quality Control is a unit within the Medical Assistance Division of the Colorado Department of Social Services. This unit is independent of and functionally different (as described below) from the Quality Control Unit described in Colorado State Department of Social Services Staff Manual 3 Section 3.870.11 et seq.
- .11 Medicaid Quality Control is a federally required ongoing review conducted by the Division of Medical Assistance to determine the extent to which third party liability or claims processed by the fiscal agent contain errors.
- .12 The Medicaid Quality Control system is a method of State administration that is intended to reduce the incidence of claims processing and third party liability errors. This is accomplished by means of three processes.
- A. A continuous review of the Medicaid claims processed for a statistically reliable statewide sample of cases;
 - B. The periodic assembly and analysis of findings to determine the incidence of errors; and
 - C. The taking of corrective action to reduce the level of error, and, if necessary, bring such error rate within established tolerance.

8.090.2 METHOD

- .20 The Medicaid Quality Control Review covers:

- A. The manner in which county departments identified and then documented recipient's third party medical insurance benefits and coverage;
 - B. Accuracy of information provided by client;
 - C. Accuracy of fiscal agent action with respect to claims processing and third party liability for paid claims.
 - D. Medically necessary transportation authorized by the State or county departments.
 - E. Medical certification for recipients in long term care facilities.
- .21 Errors are of two types:
- A. Third party liability errors - when there is a third party(ies) which is available to pay for medical services for eligible recipients, but the party(ies) was not known or fully utilized prior to claims payments.
 - B. Claims processing errors - when claims were paid which did not contain all necessary information, which did not meet the service or payment amount restrictions, or which did not reflect liability for payment correctly.
- .22 Third party liability errors are reported to the county departments by the Quality Control Unit via the Third Party Recovery Unit, Division of Medical Assistance, Colorado State Department of Social Services with requests for the county's report of corrective action.
- .23 Claims processing errors are reported to the appropriate section within the Medical Assistance Division and/or fiscal agent with requests for corrective action.
- .24 At periodic intervals, the findings of Medicaid Quality Control are assembled, tabulated, and summarized for use by the State Department of Social Services to meet federal reporting requirements.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 3/4/07, 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 3/4/07, 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]