COLORADO
Department of Health Care
Policy & Financing

1570 Grant Street
Denver, CO 80203

8.130 PROVIDER PARTICIPATION

Providers will not discriminate based on race, color, religion, age (except as provided by law), sex, marital status, political affiliation, disability, or national origin.

8.130.1 DEFINITIONS

A. “Advanced Directive” means a written instruction, such as a Living Will or Durable Power of Attorney for health care, recognized under state law, whether statutory or as recognized by the courts of the state, that relates to the provision of medical care when the individual is incapacitated.

B. "Agent" means any person who has been delegated the authority to obligate or act on behalf of a Provider.

C. “Colorado Department of Health Care Policy and Financing” or “Department” means the Colorado State governmental agency responsible for the administration of the Medical Assistance Program pursuant to Title XIX of the Social Security Act.

D. "Disclosing Provider" means a Medical Assistance Provider (other than an individual practitioner or group of practitioners), managed care entity, or fiscal agent under contract with the Department.

E. “Inactivation” means a Providers billing privileges have been stopped but can be restored upon resolution of the basis of inactivation.

F. "Indirect ownership interest" means an ownership interest in an entity that has direct or indirect ownership in the disclosing Provider.

G. "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of an institution, organization, or agency.

H. “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.

I. “Requesting Agency” means the United States Department of Health and Human Services, the Department or its designees, Department of Human Services, or the Medicaid Fraud Control

Unit, acting through their representatives who have written or other authorization to act on behalf of these agencies.

8.130.2 MAINTENANCE OF RECORDS

A. Each Provider shall:

1. Maintain legible records necessary to establish that conditions of payment for Medicaid covered services have been met, and to fully disclose the basis for the type, frequency, extent, duration, and delivery of goods and services provided to Medicaid recipients, including but not limited to:

a. Billings,

b. Prior authorization requests,

c. All medical records, service reports, and orders prescribing treatment plans,

d. Records of goods prescribed, ordered for, or furnished to, clients, and unaltered copies of original invoices for such items,

e. Records of all payments received from the Medical Assistance Program, and

f. Records required elsewhere in Section 8.000 et seq.

2. The records shall be created at the time the goods or services are provided.

B. Records of Providers shall include employment records, including but not limited to shift schedules, payroll records, and time-cards of employees.

C. Providers who issue prescriptions shall keep in the patient's record, the date of each prescription and the name, strength, and quantity of the item prescribed.

D. Records must be maintained for six (6) years unless an additional retention period is required elsewhere in Sections 8.000 et seq., or in an individual Provider participation agreement.

E. Each Provider shall retain any other records created in the regular operation of business that relate to the type and extent of goods and services provided (for example, superbills). All records must be legible, verifiable, and must comply with generally accepted accounting principles, auditing standards, and all applicable state and federal laws, rules, and regulations.

F. Each entry in a medical record must be signed and dated by the individual providing the medical service or good. Stamped signatures are not acceptable.

G. Providers utilizing electronic record-keeping may apply computerized signatures and dates to a medical record if their record-keeping systems guarantee the following security measures:

1. Restrict application of an electronic signature to the specific individual identified by the signature. System security must prevent one person from signing another person's name.

2. Prevent alterations to authenticated (signed and dated) records. If the Provider chooses to supplement a previous entry, the system must only allow a new entry that explains the supplement. The Provider must not be allowed to change the initial entry.

3. Printed or displayed electronic records must note that signatures and dates have been applied electronically.

H. At the discretion of the Requesting Agency, record verification may include, but will not be limited to, interviews with Providers, employees of Providers, billing services that bill on behalf of Providers, and any member of a corporate structure that includes the Provider as a member.

8.130.3 ADVANCE DIRECTIVES

A. Providers shall provide adult Medical Assistance program clients with written information about the individual's rights under state law to accept or refuse medical treatment, the right to formulate advance directives, and the Providers' policies regarding the implementation of such rights as follows:

1. Hospitals, at the time of the individual's admission as an inpatient.

2. Nursing facilities, at the time of the individual's admission as a resident.

3. Providers of home health care or personal care services, in advance of the individual coming under the care of the Provider.

4. Hospice programs, at the time of initial receipt of hospice care by the individual from the program.

5. Health maintenance organizations, at the time of enrollment of the individual with the organization.

B. The Provider shall maintain written policies and procedures with respect to all adult individuals receiving medical or personal care by or through the Provider organization, which shall include:

1. Documentation in the individual's medical records indicating whether the individual has executed an advance directive.

2. Documentation that the individual will not be discriminated against, nor will the provision of care be conditioned on whether he/she has executed an advance directive.

3. Documentation ensuring compliance with requirements of state law respecting advanced directives.

4. Documentation in the individual's medical record substantiating the Provider's reason(s) for non-compliance with an advance directive based on conscience or professional ethics.

C. Providers shall provide education for staff and the patient/client community on issues concerning advance directives.

8.130.35 SCREENING FOR EXCLUDED EMPLOYEES AND CONTRACTORS

A. As a condition of enrollment and participation in the Medical Assistance program, each Provider shall comply with the following requirements for screening for employees and contractors who have been excluded from participation in Medicaid and Medicare by the US Department of Health & Human Services Office of Inspector General:

1. Each Provider shall utilize the US Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities (www.oig.hhs.gov) to determine if a prospective employee or newly signed contractor has been excluded from participation in Medicaid.

   a. Such screening should be performed within five (5) business days of the date on which the new employee was hired or new contract was signed.

2. Each Provider shall screen its employees and contractors against the List of Excluded Individuals/Entities at least monthly to capture any exclusions or reinstatements that have occurred since the last search of the database.

3. If a Provider determines that an employee or contractor of the Provider has been excluded, then the Provider shall report this to the Department within five (5) business days of the date of discovery.

4. Each screening must be documented in a manner that can be provided to the Department upon request.

B. Except as otherwise provided in federal law, if the Medical Assistance program pays for any goods or services furnished, ordered, or prescribed by an excluded individual or entity that is employed by or has contracted with a Provider, such payment shall constitute an overpayment and shall be subject to the overpayment recovery, pursuant to Section 8.076. Such Provider may also be subject to sanctions by the Department, including the termination of the Provider agreement, as described at 8.076.5., if the Provider knew or should have known of the exclusion. The Provider may also be subject to civil and monetary penalties imposed by the Department of Health and Human Services.

1. To the extent that such amount can be traced, the amount of the overpayment shall include any funds expended by the Medical Assistance program to pay the excluded individual's or contractor's salary, expenses, or fringe benefits.

C. Subject to federal law and the Department's discretion, failure of a Provider to comply with the screening requirements listed at Section 8.130.35.A. may constitute good cause sufficient to justify termination of the Provider agreement, as described at 8.076.5.

8.130.40 PROVIDER LICENSES

A. As a condition of participation in the Medical Assistance program, any Provider who has employees or contractors who provide services or supplies must ensure that, at the time services or supplies are provided, the employee or contractor possesses the license, certification, or credential that is required in the State of Colorado to provide such services or supplies.

8.130.45 REPORTING CHANGES

A. Reporting Material/Substantial Changes

1. Provider shall notify the Department of any material and/or substantial change in information contained in the enrollment application given to the Department by the Provider.

2. The required notification of this section 8.130.45.A must be delivered in writing to the Department and must be updated in the Provider portal of the Department's Medicaid Management Information System (MMIS) , within thirty-five calendar days of the event triggering the reporting obligation.

3. For the purpose of this section 8.130.45.A only, a material and/or substantial change includes, but is not limited to, a change in a Provider's ownership, disclosures, licensure, certification, registration status, accreditation, federal tax identification number, bankruptcy, address, including all locations where services are rendered, contact person, telephone number, email address; and criminal convictions under 42 CFR § 455.106.

4. Failure by the Provider to notify the Department of a material and/or substantial change in accordance with this section 8.130.45.A.:

   a. May result in the denial, suspension, or termination of the Provider agreement or contract.

   b. Does not exempt a Medicaid Provider from other compliance responsibilities under Sections 8.050, 8.067 and 8.076.

8.130.50 REQUIREMENT TO VERIFY ENROLLMENT OF MEMBER AT TIME OF SERVICE

A. A Provider shall verify and document that the member is enrolled in the applicable Medical Assistance program at the time the service is rendered.

B. A Provider shall verify that payments received are for medically necessary services that were actually rendered, and that claims and encounters submitted for payment are true and correct.

8.130.60 PROVIDERS ARE RESPONSIBLE FOR ALL CLAIMS SUBMITTED

A. A Provider shall accept full legal responsibility for all claims submitted under the Provider's Medical Assistance program ID number to the Medical Assistance program, whether submitted by the Provider or submitted on the Provider's behalf.

   1. A Provider shall comply with all federal and state civil and criminal statutes, regulations, and rules relating to the delivery of benefits to eligible individuals, and to the submission of claims for such benefits. A Provider's non-compliance may result in no payment for services rendered.

B. A Provider shall furnish to the Department its National Provider Identifier (NPI) (if eligible for an NPI) and include the NPI on all claims submitted pursuant to Sections 8.125.8 and 8.126.3.

C. A Provider shall request payment only for those services which are medically necessary, as such term is defined in Section 8.076.1.8. and in any other subsection of these rules defining medical necessity, and which are rendered personally by the Provider or rendered by qualified personnel under the Provider's direct and personal supervision.

   1. A Provider shall submit claims only for those benefits provided by health care personnel who meet the professional qualifications established by the State.

   2. Any misrepresentation or falsification of a claim submitted by a Provider, or on a Provider's behalf, may subject the Provider to fines and/or imprisonment under state or federal law.

D. If at any time the Department determines that a Provider has failed to maintain compliance with any state or federal laws, rules, or regulations, the Provider may be suspended from participation in the Medical Assistance program, and may be subject to administrative actions authorized by federal or state law or regulation, criminal investigation, and/or prosecution.

8.130.70 COMPLIANCE WITH GUIDANCE

A. Providers must comply with all state or federal statutes, rules, regulations, and guidance.

B. Guidance includes, but is not limited to:

   1. Department Billing Manual
   2. Department Provider Bulletins
   3. Department Memo Series
   4. Uniform Service Coding Standards
   5. Current Procedural Terminology (CPT) code set

6. Healthcare Common Procedure Coding System (HCPCS)
7. International Classification of Diseases, Tenth Revision (ICD-10)

C. Failure to comply may subject the Provider to authorized administrative actions, civil investigation, and criminal investigation..

8.130.80 INACTIVATING PROVIDER AGREEMENTS

A. A Provider may have its Provider agreement inactivated and will no longer be able to bill for services if:

a. The Provider's license, certification, or accreditation has expired or is subject to conditions or restrictions.

b. The Provider has failed to complete Provider revalidation.

c. The Provider is no longer eligible to participate as a Medicaid Provider or breaches the Provider agreement.

d. There is a change of ownership.

e. The Provider's business closes, or the business is nonoperational.

f. The Provider is deceased or retired.

g. The Provider is inactive and has not submitted any claims activity for 24 months.

B. The Provider will receive written notice of the inactivation that will include the reason for inactivation and the date the inactivation will be effective.

C. A Provider inactivated under this Section 8.130.80 shall remain inactivated until such time as the cause of inactivation is resolved, as determined in the sole discretion of the Department.

D. If the Department determines that the cause of inactivation has been resolved, the Provider will be reinstated and may resume participation in the Medical Assistance program.