Title of Rule: Revision to Medical Assistance Act Concerning the Home Health Benefit, Section 8.520
Rule Number: MSB 24-12-31-A
Division / Contact / Phone: Benefits and Services Management / Paul Hutchings / 303-866-4944

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The Department is revising the rules and regulations governing the Home Health benefit. The Home Health Rule (10 CCR 2505-10 Section 8.520) outlines the provision of home health services under Health First Colorado (Colorado's Medicaid Program), including criteria for services, provider eligibility, covered services, and provider services. This rule is designed to serve Health First Colorado Members, both children and adults, who require in-home skilled nursing, therapies, or certified nurse aide services due to medical conditions.

   The updated Home Health Rule addresses outdated or unclear language, refines areas requiring edits, and improves overall readability. Changes include rephrasing, clarification, restructuring, and removing redundant sections where appropriate. For example, terminology adjustments, such as replacing "client" with "Member," were made to align with current standards. These modifications are essential to enhance the benefit for both Members and providers, ensuring clarity, accessibility, and effectiveness in delivering home health services.

The proposed updates to the Home Health Rule are designed to align with the recently revised Private Duty Nursing (PDN) Rules (Section 8.540), approved by the Medical Services Board on May 10, 2024. To maintain consistency between these benefits, many definitions and terms from the PDN Rules have been incorporated into the Home Health Rules. In addition, the Home Health Rule outlines using the Acuity Tool, developed in collaboration with For Health Consulting as part of the American Rescue Plan Act (ARPA) Project 6.01. This proprietary, evidence-based tool assesses medical necessity for skilled services within the Medicaid program.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain: N/A

3. Federal authority for the Rule, if any:
   42 CFR 456.6(a), 42 CFR 456.1(b)(1)

4. State Authority for the Rule:

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Section 25.5-6-113, C.R.S. and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024)

Initial Review	**04/11/25**	Final Adoption	**05/09/25**
Proposed Effective Date	**06/30/25**	Emergency Adoption	

DOCUMENT #05

Title of Rule: Revision to Medical Assistance Act Concerning the Home Health Benefit, Section 8.520
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REGULATORY ANALYSIS

5. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Health First Colorado Members of all ages will experience improved quality of care and more effective service delivery under the updated rule. This includes those who receive or may qualify for in-home skilled nursing, therapy, or certified nurse aide services. Providers will benefit from enhanced clarity and consistency in the regulations, reducing compliance challenges and increasing operational efficiency. The proposed rule will help the Department's Utilization Management (UM) vendor, Acentra Health to improve the efficiency of their decision-making processes and reduce ambiguities in determining medical necessity.

6. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The quantitative impact of the proposed rule revision is minimal and primarily involves one-time administrative costs for providers, such as staff training and updating documentation processes. The qualitative impact will likely be more significant for Health First Colorado Members. The proposed rule's emphasis on clarity will contribute to a more equitable and efficient healthcare delivery system for Members, especially those requiring complex or long-term care service. It will enhance their ability to access care, improve their experience within the Health First Colorado system, and promote better health outcomes through improved care coordination and satisfaction.

7. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The Department will incur minimal costs for implementing the revised rule, such as creating educational materials and hosting provider training sessions. Key components of the Home Health Rule change, such as the Acuity Assessment Tool created in collaboration with ForHealth Consulting through the American Rescue Plan Act (ARPA) Project 6.01 and the Nurse Assessor approved in the FY 2024-25 Budget Request R-10, are already established and will not impact the budget further. Other agencies are unlikely to incur significant costs since these revisions are specifically related to HCPF.

Additionally, the proposed rule is not anticipated to significantly affect future state revenues.

8. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The updated rule revision will improve clarity, functionality, and service delivery, ultimately enhancing Members' experience and simplifying provider compliance. Inaction would perpetuate outdated and unclear language, leading to possible confusion, inconsistent service delivery, and challenges with compliance.

9. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   Alternative methods like issuing guidance or FAQs would not fully address the structural issues in the current rule, leaving gaps in clarity and efficiency. A comprehensive rule update is necessary to resolve these problems.

10. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

    No less costly or intrusive methods could achieve the same level of improvement. Partial updates or supplemental guidance would fall short of addressing the underlying issues in the existing rule, making the comprehensive revision process essential to achieving the intended benefits for both Members and providers.

[ ] indicates that text has been stricken from the document

These codes of regulation incorporate by reference (as indicated within) material originally published elsewhere. Such incorporation, however, excludes later amendments to, or editions of the referenced material. 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 303 E. 17th Avenue Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

8.520 HOME HEALTH SERVICES

8.520.1. Definitions

8.520.1.A. Activities of Daily Living (ADL) means daily tasks that are required to maintain a [~~client~~]Member's health, which ~~and~~ includes but not limited to eating, bathing, dressing, toileting, grooming, transferring, walking, and continence. When a [~~client~~]Member is unable to perform these activities independently, skilled or unskilled providers may be required for the ~~client~~Member's needs.

[~~8.520.1.B.~~] 8.520.1.B~~C~~. Acute Medical Condition means a medical condition which has a rapid onset and short duration. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

[~~8.520.1.C.~~] 8.520.1.C~~D~~. Alternative Care Facility means an A~~a~~ssisted L~~l~~iving R~~r~~esidence licensed by the Colorado Department of Public Health and Environment (CDPHE) and certified by the Department of Health Care Policy and Financing (Department) to provide Assisted Living Care Services and Protective Oversight to [~~client~~]Members.

[~~8.520.1.D.~~] 8.520.1.~~E~~D. Behavioral Intervention means techniques, therapies, and methods used to modify or minimize aggressive (verbal/physical), combative, destructive, disruptive, repetitious, resistive, self-injurious, or other inappropriate behaviors outlined on the CMS-485 Plan of Care, or a form that is of similar format to the CMS-485, (defined below). Behavioral interventions exclude frequent verbal redirection or additional time to transition or complete a task, which are part of the general assessment of the [~~client~~]Member's needs.

8.520.1.E. Brief Nursing Visit means those Skilled Nursing Services that are provided to a Member who requires multiple visits per day for skilled tasks that can be completed in a shorter or brief visit as compared to a Standard Nursing Visit (excluding the first regular nursing visit of the day).

8.520.1.F[~~G.~~ ~~8.520.1.E.~~] Care Coordination means the deliberate organization of [~~ient~~]-Member care activities between two or more participants (including the [~~client~~]Member) for the appropriate delivery of health care and health support services, and organization of personnel and resources needed for required [~~clientcare~~]-Member activities.

8.520.1.G[~~H.~~ ~~8.520.1.F.~~] Certified Nurse Aide Assignment Form means the form used by the Home Health Agency to list the duties to be performed by the Certified Nurse Aide (CNA) at each visit as per the Department of Public Health and Environment Health Facilities Regulation Division Standards for Hospitals and Health Facilities Chapter 26, Home Care Agencies 6 CCR 1011-1 Chapter 26 Section 7.15.

8.520.1.H[I]. Chronic Medical Condition means a medical condition that lasts more than one year [or more] and requires ongoing medical attention, or limits Activities of Daily Living, [or] both.

8.520.1.I[[J. 8.520.1.G.] Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency.[which is designated as the single State Medicaid agency for Colorado, or any divisions or sub-units within that agency.]]

[8.520.1.H.] 8.520.1.[K]J. Designee means the entity that has been contracted by the Department to review for the Medical Necessity and appropriateness of the requested services, including Home Health prior authorization requests (PARs). Designees may include case management entities such as Single Entry Points or Community Centered Boards who manage waiver eligibility and review.

[8.520.1.L. Direct Care Worker means a non-administrative employee or independent Contractor of a Home Health Agency who provides hands-on care, services, and support to individuals with disabilities across the Long-Term Services and Supports continuum within Home and Community-Based settings.]

8.520.1.K[M.] Family/In-Home Caregiver means an individual who assumes a portion of the Member's care in the home in the absence of agency staff. A Family/In-Home Caregiver may either live in the Member's home or travel to the Member's home to provide care.

[8.520.1.I. Home Care Agency means an entity which provides Home Health or Personal Care Services. When referred to in this rule without a 'Class A' or 'Class B' designation, the term encompasses both types of agencies.]

8.520.1.L[N. 8.520.1.J.]Home Health Agency (HHA) means an agency or organization that is certified for participation as a Medicare Home Health Provider [under Title XVIII of the Social Security Act and licensed as a Class A Home Care Agency through the Colorado Department of Public Health and Environment.]pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A Home Care Agency as required by § 25-27.5-103(1), C.R.S. [Home Health Agency means an agency that is licensed as a Class A Home Care Agency in Colorado, and is certified to provide skilled care services to Medicare and Medicaid eligible clients. Agencies shall hold active and current Medicare and Medicaid provider IDs to provide services to Medicaid clients.]

8.520.1.M[O. 8.520.1.K.]Home Health Services means those services listed at Section 8.520.5, Service Types.

[8.520.1.L. Home Health Telehealthmeans the remote monitoring of clinical data transmitted through electronic information processing technologies, from the client to the home health provider which meet HIPAA compliance standards.]

8.520.N[P. 8.520.1.M.]Intermittent means visits that have a distinct start time and stop time, and are task oriented with the goal of meeting a [client]Member's specific needs for that visit.

8.520.O[Q.] Medical Necessity is defined in Program Integrity rules (10 CCR 2505-10Section 8.076.1.8). For children 20 and younger, this is further defined to include the requirements outlined in the Early and Periodic Screening, Diagnosis, and Treatment rules (10 C.C.R. 2505-10Section 8.280.1.).

8.520.P. Member means any person who is eligible for and is enrolled in the Colorado Medical Assistance Program.

[8.520.1.N. Ordering Practitioner means the client's primary care physician, nurse practitioner, clinical nurse specialist, physician assistant, or other physician specialist. For clients in a hospital

~~or nursing facility, the Ordering Practitioner is the appropriate qualified personnel responsible for writing discharge orders until such time as the client is discharged. This definition may include an alternate practitioner authorized by the Ordering Practitioner to care for the clientin the Ordering Practitioner's absence.~~]

8.520.1.Q[~~P~~] Personal Care Worker means an employee of a licensed Home Care Agency who has completed the required training to provide Personal Care ~~Serivces~~Services, or who has verified experience providing Personal Care Services to Members. A Personal Care Worker shall not perform tasks that are considered skilled Nursing or CNA services.

[~~8.520.1.O. Personal Care Worker means an employee of a licensed Home Care Agency who has completed the required training to provide Personal Care Services, or who has verified experience providing Personal Care Services for clients. A Personal Care Worker shall not perform tasks that are considered skilled CNA services.~~]

8.520.1.R.[~~Q~~] Nurse Assessor Vendor means a third-party vendor contracted by the Department to complete the Skilled Care Acuity Assessment for specific skilled care services.

8.520.1.S[~~RQ~~.] Physician or Allowed Practitioner means a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) who oversees the delivery of skilled care to a Member within their scope of practice, in accordance with State law, and ~~who~~ is actively enrolled with Health First Colorado.

8.520.1.T. [~~S8.520.1.P.~~]Place of Residence means where the [~~client~~]Member lives. Includes temporary accommodations, homeless shelters or other locations for [~~client~~]Members who are homeless or have no permanent residence.

[~~8.520.1.Q. Plan of Care means a coordinated plan developed by the Home Health Agency, as ordered by the Ordering Practitioner for provision of services to a client at his or her residence, and periodically reviewed and signed by the practitioner in accordance with Medicare requirements. This shall be written on the CMS-485 ("485") or a document that is identical in content, specific to the discipline completing the plan of care.~~]

8.520.1.U[~~TS~~]. Plan of Care (POC) means a completed Centers for Medicare and Medicaid Services (CMS) Form 485, or a form that is of similar format to the CMS-485, also referred to as a care plan developed by the HHA in consultation with the Member, that has been ordered by the Physician or Allowed Practitioner for the provision of services to a Member at his/her residence or community setting, and is periodically reviewed and signed by the Physician or Allowed Practitioner in accordance with Medicare requirements at 42 C.F.R. § 484.18.

8.520.1.V.[~~VU~~. ~~8.520.1.R.~~]Pro Re Nata (PRN) means as needed.

[~~8.520.1.S. Protective Oversight means maintaining an awareness of the general whereabouts of a client. Also includes monitoring the clients activity so that a caregiver has the ability to intervene and supervise the safety, nutrition, medication, and other care needs of the client.~~]

8.520.1.W.[~~WV~~] Protective Oversight is ~~the required~~ supervision of the Member to prevent or mitigate disability, memory, or cognitive functioning-related behaviors or impairment~~,~~ that may result in imminent harm to self, people, or property.

8.520.1.X.[~~XW.~~] Remote Patient Monitoring means the remote monitoring of clinical data transmitted through electronic information processing technologies, from the Member to the home health provider, which meet HIPAA compliance standards.

8.520.1.Y. Skilled Care Acuity Assessment means the proprietary assessment that will be used to assess Members for their skilled care needs. The Skilled Care Acuity Assessment will only be accepted as valid documentation when completed by the authorized Nurse Assessor Vendor. The Assessment was finalized on September 25, 2024 and is available at https://hcpf.colorado.gov/nurse-assessor. []

8.520.1.Z.[~~YX.~~] Skilled Nursing/Skilled Nursing Service means services provided under the licensure, scope, and standards of the Colorado Nurse and Nurse Aide Practice Act~~,~~ (Title 12 Article ~~-~~255 of the Colorado Revised Statutes), performed by a registered nurse (RN) under the direction of a Physician or Allowed Practitioner, or a licensed practical nurse (LPN) under the supervision of an RN and the direction of a Physician or Allowed Practitioner, for care that cannot be delegated by the judgment of the nurse.

8.520.1.AA.[~~ZY.~~] Standard Nursing Visit means those Skilled Nursing Services that are provided to a Member by a registered nurse (RN) under applicable state and federal laws and professional standards or licensed practical nurse (LPN) under the direction of a RN to the extent allowed under applicable state and federal laws.

8.520.1.BB.[~~AAZ.~~] ~~Utilization Review Contractor (URC)~~ Utilization Review Contractor (URC) means a third-party vendor contracted by the Department to perform utilization management functions for specific services.

8.520.2. Criteria for Services [~~Client Eligibility~~]

8.520.2.A. Home Health Services are available to all ~~Medicaid [client]~~Members and to all Old Age Pension Program [~~client~~]Members, as defined at Section 8.940, when all program and service requirements in this rule are met.

[~~8.520.2.B.~~

~~Medicaid clients aged 18 and over shall meet the Level of Care Screening Guidelines for Long-Term Care Services at Section 8.401, to be eligible for Long-Term Home Health Services, as set forth at Section 8.520.4.C.2.]~~

8.520.3. Provider Eligibility

8.520.3.A. Services must be provided by a Medicare and Medicaid-certified Home Health Agency.

8.520.3.B. All Home Health Agency[~~Services~~] providers shall comply with the rules and regulations set forth by the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, the Colorado Department of Regulatory Agencies, the Centers for Medicare and Medicaid Services, and the Colorado Department of Labor and Employment.

8.520.3.C. Provider Agency Requirements

1. A Home Health Agency must:

   a. Be certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act;

   b. Be a Colorado Medicaid enrolled provider;

   c. Maintain liability insurance for the minimum amount set annually ~~-~~as outlined in 6 CCR 1011-1 Chapter 26[~~by the Department~~]; and

   d. [~~Be licensed by the~~]Hold a State of Colorado [~~as a~~]Class A Home Care Agency license in good standing.

   e. [~~All Home Health Agency providers shall c~~]Comply with applicable regulations promulgated by the Board of Health, Medical Services Board, Medical Board, Nursing Board, Department of Labor and Employment, and the Centers for Medicare and Medicaid Services.

2. Home Health Agencies which perform procedures in the [~~client~~]Member's home that are considered waivered clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 shall possess a certificate of waiver from the Centers for Medicare and Medicaid Services (CMS) or its Designee.

3. Home Health Agencies shall regularly review the Medicaid rules, 10 CCR 2505-10. The Home Health Agency shall make access to these rules available to all staff.

4. A Home Health Agency cannot discontinue or refuse services to a [~~client~~]Member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal. The Home Health Agency must provide notice of at least [~~thirty~~]30 calendar days to the [~~client~~]Member, or the [~~client~~]Member's designated representative. [~~legal guardian.~~]

5. In the event a Home Health Agency is ceasing operations, provider agencies must notify the Department within 30 calendar days. The notification must be submitted through the Provider Portal as a maintenance application for the disenrollment request. The provider must also email the Department the notice to[~~as~~] the designated Home Health inbox.[~~or ceasing services to Medicaid clients, the agency will provide notice to the Department's Home Health Policy Specialist of at least thirty days prior to the end of operations.~~]

6. Colorado Adult Protective Services (CAPS) and Criminal Background Checks

   a. Home Health Agencies shall conduct criminal background checks and reference checks and compare the employee's/independent c~~C~~ontractor's name against the list of all currently excluded individuals maintained by the Office of Inspector General prior to employing staff or hiring independent c~~C~~ontractors to provide services and supports to Members. All costs related to obtaining a criminal background check shall be borne by the Provider Agency. Background checks shall be completed every five years for each employee and c~~C~~ontractor who provides direct care to Members.

b. Home Health Agencies shall comply with the CAPS check requirements set forth at § 26-3.1- 111(6)(a), C.R.S. and 12 C.C.R. 2518-1, § 30.960.G-J. The Home Health Agency shall maintain accurate records and make records available to the Department upon request.

i) HCPF or its Designee shall act as the oversight agency ~~Home Health Agency~~ described at § 26-~~-~~3.1-111(6)(a)(III), C.R.S. and shall receive CAPS check results for Home Health Agencies requiring Certification, the prospective Agency shall:

1) Submit to the CDPHE a copy of the CAPS check results as part of their initial application for Certification.

i) Substantiated findings as outlined in Section 8.7409 E.2.b may result in the denial of the Medicaid enrollment application.

ii) Direct Care Workers with any of the following are prohibited from providing direct care to any Member:

1) An allegation of Mistreatment, Abuse, Neglect and Exploitation (MANE) or harmful act, as defined in Section 26-3.1-101, C.R.S., substantiated by Adult Protection Services (APS) within the last 10 years, at a "S~~s~~everity L~~l~~evel" of "Moderate" or "Severe" as defined in 12 C.C.R. 2518-1; Section 30.100;

2) Three or more allegations of MANE or harmful act, as defined in Section 26-3.1-101, C.R.S., substantiated by APS within the last five years, at the minor severity level as defined in 12 C.C.R. 2518; Section 30.100; or

3) A criminal conviction of MANE against an at-risk adult defined at § 26-3.1- 101, C.R.S.

4) Only substantiated allegations for which the state level appeal process as defined as 12 C.C.R. 2518-1; Section 30.920 has concluded shall be included in the above exclusions list.

8.520.4. Covered Services

8.520.4.A. Home Health Services are covered under Medicaid only when all of the following are met:

1. Services are Medically Necessary as defined in Section 8.520.1., Definitions;
2. Services are provided under a Plan of Care as defined at Section 8.520.1., Definitions;
3. Services are provided on an Intermittent basis, as defined at Section 8.520.1., Definitions;
4. The [~~client~~]Member meets one of the following:

a. The only alternative to Home Health Services is hospitalization or emergency room care or other institutionalization; or

b. [~~Client~~]Member medical records indicate that medically necessary services should be provided in the [~~client~~]Member's P[~~p~~]lace of R[~~r~~]esidence or community, instead of an outpatient setting, according to one or more of the following guidelines:

i) The [~~client~~]Member, due to illness, injury or disability, is unable to travel to an outpatient setting for the needed service;

ii) Based on the [~~client~~]Member's illness, injury, or disability, travel to an outpatient setting for the needed service would create a medical hardship for the [~~client~~]Member;

iii) Travel to an outpatient setting for the needed service is contraindicated by a documented medical diagnosis;

iv) Travel to an outpatient setting for the needed service would interfere with the effectiveness of the service; or

v) The [~~client~~]Member's medical diagnosis requires teaching which is most effectively accomplished in the [~~client~~]Member's P[~~p~~]lace of R[~~r~~]esidence on a short-term basis.

5. The [~~client~~]Member is unable to perform the health care tasks for him or herself, and no [~~unpaid family/caregiver~~]Family/In-Home Caregiver is able ~~and~~ or willing to voluntarily perform the tasks; and

a. Family/In-Home Caregiver responsibilities should be guided by age-appropriate expectations to distinguish when a Member's needs require care beyond typical caregiving duties due to the skilled nature of needs and/or intensity of need.

6. Covered service types are those listed in Service Types, Section 8.520.5.

8.520.4.B. Place of Service

1. Services shall be provided in the [~~client~~]Member's P[~~p~~]lace of R[~~r~~]esidence or one of the following places of service:

a. Assisted Living [~~Facilities (ALFs)~~]~~;~~ Residence (ALR);

b. Alternative Care Facilities (ACFs);

c. Group Residential Services and Supports (GRSS) including licensed group homes servicing[~~e~~] four to eight Members [~~host homes, apartments or homes where three or fewer clients reside.~~] Services shall not duplicate those that are the contracted responsibility of the GRSS;

d. Individual Residential Services and Supports (IRSS) including host homes, apartments or homes where three or fewer [~~client~~]Members reside. Services shall not duplicate those that are the contracted responsibility of the IRSS; or

e. Hotels, or similar temporary accommodations while traveling, will be considered the temporary P[~~p~~]lace of R[~~r~~]esidence for purposes of this rule.

f. Nothing in this section should be read to prohibit a [~~client~~]Member from receiving Home Health Services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

g. Telemedicine may be provided in accordance with Section 8.095.

8.520.4.C. Service Categories

1. Acute Home Health Services

a. Acute Home Health Services are covered for [~~client~~]Members who experience an acute health care need that requires Home Health Services.

b. Acute Home Health Services are provided for 60 or fewer calendar days or until the A[~~a~~]cute M[~~m~~]edical C[~~c~~]ondition is resolved, whichever comes first.

c. Acute Home Health Services are provided for the treatment of the following A[~~a~~]cute M[~~m~~]edical C[~~c~~]onditions/episodes that [~~could~~]include but are not limited to:

i) Infectious disease;

ii) Pneumonia;

iii) New diagnosis of a life-altering disease;

iv) Post-heart attack or stroke;

v) Care related to post-surgical recovery;

vi) Post-hospital care provided as follow-up care for medical conditions that required hospitalization, including neonatal disorders;

vii) Post-nursing home care, when the nursing home care was provided primarily for rehabilitation following hospitalization and the medical condition is likely to resolve or stabilize to the point where the [~~client~~]Member will no longer need Home Health Services within 60 days following initiation of Home Health Services;

viii) Complications of pregnancy or postpartum recovery; or

iv) Individuals who experience an acute incident related to a chronic disease may be treated under the acute home health benefit. Specific information on the acute incident shall be documented in the record.

d. A [~~client~~]Member may receive additional periods of acute Home Health Services when at least 10 days have elapsed since the [~~client~~]Member's discharge from an acute home health episode and one of the following circumstances occurs:

i) The [~~client~~]Member has a change in medical condition that necessitates acute Home Health Services;

ii) New onset of a C[~~c~~]hronic M[~~m~~]edical C[~~c~~]ondition; or

iii) Treatment needed for a new A[~~a~~]cute M[~~m~~]edical C[~~c~~]ondition or episode.

e. Nursing visits provided solely for the purpose of assessment or teaching are covered only during the acute period under the following guidelines:

i) An initial assessment visit ordered by a Physician or Allowed Practitioner [~~physician~~] is covered for determination of whether ongoing nursing or CNA care is needed. Nursing visits for the sole purpose of assessing a [~~client~~]Member for recertification of Home Health Services shall not be reimbursed if the [~~client~~]Member receives only CNA services;

ii) The visit instructs the [~~client~~]Member or [~~client~~]Member's [~~family member/caregiver~~] Family/In-Home Caregiver in providing safe and effective care that would normally be provided by a skilled home health provider; or

iii) The visit supervises the [~~client~~]Member or [~~client~~]Member's [~~family member/caregiver~~] Family/In-Home Caregiver to verify and document that they are competent in providing the needed task.

f. Acute Home Health Services may be provided to [~~client~~]Members who receive Health Maintenance tasks through In-Home Supports and Services (IHSS) or Consumer Directed Attendant Supports and Services (CDASS).

g. GRSS group home residents may receive acute Home Health Services.

h. If the acute home health [~~client~~]Member is hospitalized for planned or unplanned services for 10 or more calendar days, the Home Health Agency may close the [~~client~~]Member's acute home health episode and start a new acute home health episode when the [~~client~~]Member is discharged.

i. Acute Care Home Health Limitations:

i) A new period of acute Home Health Services shall not be used for continuation of treatment from a prior Acute Home Health episode. New Acute Episodes must be utilized for a new or worsening condition.

ii) A [~~client~~]Member who is receiving either Long-Term Home Health Services or HCBS waiver services may receive acute Home Health Services only if the [~~client~~]Member experiences an event listed in subpart c. as an acute incident, which is separate from the standard needs of the[~~client~~] Member and makes acute Home Health Services necessary.

iii) If a [~~client~~]Member's A[~~a~~]cute M[~~m~~]edical C[~~c~~]ondition resolves prior to 60 calendar days from onset, the [~~client~~]Member shall be discharged from acute home health or transitioned to the [~~client~~]Member's normal Long-Term Home Health S[~~s~~]ervices.

2. Long-Term Home Health Services

a. Long-T[t]erm Home Health Services are covered for [~~client~~]Members who have long-term chronic needs requiring [~~ongoing~~]Home Health Services.

b. Long-T~~t~~erm Home Health Services may be provided to [~~client~~]Members who receive health maintenance tasks through IHSS.

c. ~~[Long-Tterm Home Health Services may not be provided to clientMembers who receive health maintenance tasks through CDASS].~~

C[~~d~~]. Long-T[t]erm Home Health Services are provided:

i) Following the 60th calendar day for acute home health [~~client~~]Members who require additional services to meet treatment goals or to be safely discharged from Home Health Services;

ii) On the first day of Home Health Services for [~~client~~]Members with well documented chronic needs when the [~~client~~]Member does not require an acute home health care transition period; or

iii) Continuation of [~~ongoing~~]long-term home health Plan of Care.

d~~e~~. Long-Term Home Health Limitations:

i) [~~Client~~]Members aged 20 and younger may obtain long-term home health physical therapy, occupational therapy, and speech therapy services when Medically Necessary and when:

1) Therapy services will be more effective if provided in the home setting; or

2) Outpatient therapy would create a hardship for the [~~client~~]Member.

ii) [~~Client~~]Members aged 21 and older who continue to require physical therapy, occupational therapy, and speech therapy services after the initial acute home health period may only obtain such long-term services in an outpatient setting.

~~[iii) Clients admitted to Long-Term Home Health Services through the HCBS waiver program shall meet level of care criteria to qualify for long-term Home Health Services.]~~

iv) Long-T[t]erm Home Health Services may be provided in GRSS group home settings, when the GRSS provider agency reimburses the Home Health Agency directly for these Home Health Services. Long-term Home Health Service provision in GRSS group homes is not reimbursable through the State Plan.

v) Long-Term Home Health Services may be provided in IRSS settings when the IRSS provider agency reimburses the Home Health Agency directly for these Home Health Services. Long-term Home Health Service

provision in IRSS is not a Medicaid reimbursable service. ~~through the State Plan~~.

1) CNA services are not permitted within IRSS settings, and if such services are required, the IRSS provider agency must contract with the HHA for these services independently. CNA services can be provided under the per diem reimbursement structure.

2) Standard Nursing Visits are covered as long as they are not duplicative of what is already provided by the IRSS.

3. Long-Term with Acute Episode Home Health:

a. An episode is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

b. Long-term with acute episode home health is covered if the [~~client~~]Member is receiving long-term H[~~h~~]ome H[~~h~~]ealth S[~~s~~]ervices and requires treatment for an acute episode as defined in S~~s~~ection 8.520.4.C.1.

8.520.5. Service Types

8.520.5.A. Nursing Services

1. Standard Nursing Visit

a. Those Skilled Nursing Services that are provided by a registered nurse under applicable state and federal laws, and professional standards;

b. Those S[~~s~~]killed N[~~n~~]ursing S[~~s~~]ervices provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws and professional standards;

c. Standard Nursing Visits include but are not limited to:

i. 1st medication box fill (medication pre-pouring) of the week;

ii. 1st visit of the day; the remaining visits shall utilize brief nursing units as appropriate;

iii. Insertion or replacement of indwelling urinary catheters;

iv. Colostomy and ileostomy stoma care; excluding care performed by [~~Client~~]Members;

v. Treatment of decubitus ulcers (stage 2 or greater);

vi. Treatment of widespread, infected or draining skin disorders;

vii. Wounds that require sterile dressing changes;

viii. Visits for foot care;

ix. Nasopharyngeal, tracheostomy aspiration or suctioning, ventilator care;

x. [~~Bolus or continuous Levin tube and gastrostomy (G-tube) feedings,~~] Bolus or continuous nasogastric tube and/or gastrostomy (G-tube) feedings, when formula/feeding needs to be prepared or more than one (1) can of prepared formula is needed per bolus feeding per visit, ONLY when there is not an able or willing caregiver; and

xi. Complex Wound care requiring packing, irrigation, and application of an agent prescribed by the Physician or Allowed Practitioner [~~physician~~].

2. Brief Nursing Visits

a. Brief N[~~n~~]ursing V[~~v~~]isits are for established long-term home health [~~Client~~]Members who require multiple visits per day for uncomplicated skilled tasks that can be completed in a shorter or brief visit. Brief Nursing V~~v~~isits cannot be [~~(excluding~~] the first [~~regular~~] nursing visit of the day.~~)~~

b. Brief Nursing Visits include, but are not limited to:

i) Consecutive visits for two or more [~~Client~~]Members who reside in the same location and are seen by the same Home Health Agency nurse.~~, excluding the first visit of the day;~~

ii) Intramuscular, intradermal and subcutaneous injections[~~(including insulin)~~]when required multiple times daily~~, excluding the first visit of the day;~~

iii) Insulin administration: if the sole reason for a daily visit or multiple visits per day, the first visit of the week is to be treated as a S[~~s~~]tandard N[~~n~~]ursing V[~~v~~]isit and all other visits of the week are to be treated as B[~~b~~]rief N[~~n~~]ursing V[~~v~~]isits.

iv) Additional visits beyond the first visit of the day where simple wound care dressings are the sole reason for the visit;

v) Additional visits beyond the first visit of the day where catheter irrigation is the sole reason for the visit;

vi) Additional visits beyond the first visit of the day where external catheterization, or catheter care is the sole purpose for the visit;

vii) [~~Bolus Levin or G-tube feedings~~] Bolus or continuous nasogastric tube and/or gastrostomy (G-tube) feedings [~~of one can~~] of prepared formula [~~excluding the first visit of the day,~~]ONLY when there is no willing or able caregiver and it is the sole purpose of the visit;

viii) Medication box refills or changes following the first medication pre-pouring of the week;

ix) Other non-complex nursing tasks as deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate; or

x) A combination of uncomplicated tasks when deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate.

c. Ongoing assessment shall be billed as B[~~b~~]rief N[~~n~~]ursing V[~~v~~]isits unless the [~~Client~~]Member experiences a change in status requiring a standard visit. If a S[~~s~~]tandard N[~~n~~]ursing V[~~v~~]isit is required for the assessment, the agency shall provide documentation supporting the need on the PAR form and on the Plan of Care for the Department or its Designee.

3. PRN Nursing Visits

a. May be S[~~s~~]tandard N[~~n~~]ursing V[~~v~~]isits or B[~~b~~]rief N[~~n~~]ursing V[~~v~~]isits; and

b. Shall include specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.

4. Nursing Service Limitations

a. Nursing assessment visits are not covered if provided solely to open or recertify the case for CNA services, physical, occupational, or speech therapy.

b. Nursing visits solely for recertifying a [~~Client~~]Member for home health services are not covered.

c. Nursing visits that are scheduled solely for CNA supervision are not covered.

d. [~~Family member/caregivers~~] Family/In-Home Caregivers, who meet the requirements to provide nursing services and are nurses credentialed by, and in active status with the Department of Regulatory Agencies, may be employed by the Home Health Agency to provide nursing services to a ~~Client~~Member, but may only be reimbursed for services that exceed the usual responsibilities of the ~~Family Member/Caregiver~~Family/In-Home Caregiver.

e. PRN nursing visits may be requested as S~~s~~tandard N~~n~~ursing V~~v~~isits or B~~b~~rief N~~n~~ursing V~~v~~isits and shall include a ~~physician's~~ Physician or Allowed Practitioner's order with specific criteria and circumstances that warrant a PRN visit along with the specific number of PRN visits requested for the certification period.

f. Nursing visits are not reimbursed by Medicaid if solely for the purpose of psychiatric counseling or Protective Oversight, because that is the responsibility of the Behavioral Health Organization. Nursing visits for ~~mentally ill~~ ~~Client~~Members are reimbursed under Home Health Services for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.

g. Medicaid does not reimburse for two nurses during one visit except when two nurses are required to perform a procedure. For this exception, the provider may bill for two visits, or for all units for both nurses. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

h. Nursing visits provided solely for the purpose of assessing or teaching are reimbursed by the Department only in the following circumstances:

i) Nursing visits solely for the purpose of assessing the ~~Client~~Member or teaching the ~~Client~~Member or the ~~Client~~Member's ~~unpaid family member/caregiver~~ Family/In-Home Caregiver are not reimbursed unless the care is acute home health or long-term home health with acute episode, per Section 8.520.3, or the care is for extreme instability of a C~~c~~hronic M~~m~~edical C~~c~~ondition under long-term home health, per Section 8.520.3. Long-term home health nursing visits for the sole purpose of assessing or teaching are not covered.

ii) When an initial assessment visit is ordered by a ~~physician~~ Physician or Allowed Practitioner, and there is a reasonable expectation that ongoing nursing or CNA care may be needed. Initial nursing assessment visits cannot be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.

iii) When a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the ~~Client~~Member or the ~~Client~~Member's ~~unpaid family member/caregiver~~ Family/In-Home Caregiver how to perform the task, the visit is not considered as being solely for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the ~~Client~~Member or ~~unpaid family member/caregiver~~ Family/In-Home Caregiver performing the task to verify that the task is being performed correctly is considered a visit that is solely for the purpose of assessing and teaching and is not covered.

iv) Nursing visits provided solely for the purpose of assessment or teaching cannot exceed the frequency that is justified by the ~~Client~~Member's documented medical condition and symptoms. Assessment visits may continue only as long as there is documented clinical need for assessment, management, and reporting to ~~physician~~ Physician or Allowed Practitioner of specific medical conditions or symptoms which are not stable or not resolved. Teaching visits may be as frequent as necessary, up to the maximum reimbursement limits, to teach the ~~Client~~Member or the ~~Client~~Member's ~~unpaid family member/caregiver~~ Family/In-Home Caregiver, and may continue only as long as needed to demonstrate understanding or to perform care, or until it is determined that the ~~Client~~Member or ~~unpaid family member/caregiver~~ Family/In-Home Caregiver is unable to learn or to perform the skill being taught. The visit in which the nurse determines that there is no longer a need for assessment or teaching shall be reimbursed if it is the last visit provided solely for assessment or teaching.

v) Nursing visits provided solely for the purpose of assessment or teaching are not reimbursed if the ~~Client~~Member is capable of self-assessment and of contacting the ~~physician~~ Physician or Allowed Practitioner as needed, and if the ~~Client~~Member's medical records do not justify a need for ~~Client~~Member teaching beyond that already provided by the hospital or attending ~~physician~~ Physician or Allowed Practitioner, as determined and documented on the initial Home Health assessment.

vi) Nursing visits provided solely for the purpose of assessment or teaching cannot be reimbursed if there is an available and willing ~~unpaid family member/caregiver~~ Family/In-Home Caregiver who is capable of assessing the ~~Client~~Member's medical condition and needs and

contacting the ~~physician~~ Physician or Allowed Practitioner as needed; and if the ~~Client~~Member's medical records do not justify a need for teaching of the ~~Client~~Member's ~~unpaid family member/caregiver~~ Family/In-Home Caregiver beyond the teaching already provided by the hospital or attending ~~physician~~ Physician or Allowed Practitioner, as determined and documented on the initial Home Health assessment.

i. Nursing visits provided solely for the purpose of providing foot care are reimbursed by Medicaid only if the ~~Client~~Member has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the ~~Client~~Member or ~~unpaid family member/caregiver~~ Family/In-Home Caregiver is not able or willing to provide the foot care.

j. Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit. The clinical record shall indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for foot care to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:

i) Absent (not palpable) posterior tibial pulse;

ii) Absent (not palpable) dorsalis pedis pulse;

iii) Three of the advanced trophic changes:

1) Hair growth (decrease or absence),

2) Nail changes (thickening),

3) Pigmentary changes (discoloration),

4) Skin texture (thin, shiny), or

5) Skin color (rubor or redness);

iv) Claudication ~~(limping, lameness)~~;

v) Temperature changes (cold feet);

vi) Edema;

vii) Paresthesia; or

viii) Burning.

k. Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers are reimbursed only if:

i) The ~~Client~~Member is not living in a licensed Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to

pre-pour medications under the medication administration law at Section 25-1.5-301 C.R.S.;

ii) The ~~Client~~Member is not physically or mentally capable of pre-pouring medications or has a medical history of non-compliance with taking medications if they are not pre-poured;

iii) The ~~Client~~Member has no ~~unpaid family member/caregiver~~ Family/In-Home Caregiver who is willing or able to pre-pour the medications for the ~~Client~~Member; and

iv) There is documentation in the ~~Client~~Member's chart that the ~~Client~~Member's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular ~~Client~~Member.

l. The unit of reimbursement for nursing services is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~Client~~Member care or treatment.

8.520.5.B. Certified Nurse Aide Services

1. CNA services may be provided when a nurse or therapist determines that an eligible ~~client~~Member requires the skilled services of a qualified CNA, as such services are defined in this S~~s~~ection 8.520.5.B.13

2. CNA tasks shall not duplicate waiver services or the ~~client~~Member's residential agreement (such as an ALR~~F~~, IRSS, GRSS, or other Medicaid reimbursed Residence, or adult day care setting).

3. Skilled care shall only be provided by a CNA when a ~~client~~Member is unable to independently complete one or more ADLs. Skilled CNA services shall not be reimbursed for tasks or services that are the contracted responsibilities of an ALR~~F~~, IRSS, GRSS or other Medicaid reimbursed Residence.

4. Before providing any services, all CNAs shall be trained and certified according to Federal Medicare regulations, and all CNA services shall be supervised according to Medicare Conditions of Participation for Home Health Agencies found at 42 CFR § 484.36. Title 42 of the Code of Federal Regulations, Part 484.36 as amended effective March 2025 ~~Part 484.36 (2013)~~ 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, 303 E. 17th Avenue Denver, CO 80203 ~~1570 Grant Street, Denver, CO 80203~~. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

5. If the ~~client~~Member receiving CNA services also requires and receives S~~s~~killed N~~n~~ursing care or physical, occupational or speech therapy, the supervising registered nurse or therapist shall make on-site supervisory visits to the ~~client~~Member's home no less frequently than every ~~two weeks~~14 calendar days.

6. If the ~~client~~Member receiving CNA services does not require S~~s~~killed N~~n~~ursing care or physical, occupational or speech therapy, the supervising registered nurse shall make on-site supervisory visits to the ~~client~~Member's home no less frequently than every 60 calendar days. Each supervisory visit shall occur while the CNA is providing care. Visits by the registered nurse to supervise and to reassess the care plan are considered costs of providing the CNA services and cannot be billed to Medicaid as nursing visits.

7. Registered nurses and physical, occupational and speech therapists supervising CNAs shall comply with applicable state laws governing their respective professions.

8. CNA services can include personal care and homemaking tasks if such tasks are completed during the skilled care visit and are defined below:

   a. Personal care or homemaking services which are directly related to and secondary to skilled care are considered part of the skilled care task and are not further reimbursed. For ~~client~~ Members who are also eligible for HCBS personal care and homemaker services, the units spent on personal care and homemaker services may not be billed as CNA services.

   b. Nurse aide tasks performed by a CNA pursuant to the nurse aide scope of practice defined by the State Board of Nursing but does not include those tasks that are allowed as personal care, at Section 8.535, ~~PEDIATRIC PERSONAL CARE~~ Pediatric Personal Care.

   c. Personal care means those tasks which are allowed as personal care at Section 8.7538, Home and Community Based Services, Personal Care.~~Personal care means those tasks which are allowed as personal care at Section 8.7527535, PEDIATRIC PERSONAL CARE, and Section 8.7583489, HOME AND COMMUNITY BASED SERVICES-EBD -EBD, PERSONAL CARE.~~

   d. Homemaking means those tasks allowed as homemaking tasks at Section 8.7527~~490~~, ~~HOME AND COMMUNITY BASED SERVICES. - EBD, HOMEMAKER SERVICES.~~Home and Community Based Services-EBD, Homemaker Services.

9. CNA services solely for the purpose of behavior management or Protective Oversight are not a benefit under Medicaid Home Health~~, because behavior management is outside the nurse aide scope of practice.~~

10. The usual frequency of all tasks is as ordered by the ~~Ordering Practitioner~~ Physician or Allowed Practitioner on the Plan of Care unless otherwise noted.

11. The Home Health Agency shall document the decline in medical condition or the need for all medically necessary skilled tasks.

12. Skilled Certified Nurse Aide Tasks

   a. Ambulation

      i) Task includes: Walking or moving from place to place with or without assistive device.

      ii) Ambulation is a skilled task when:

1) ~~Client~~Member is unable to assist or direct care;

2) Hands on assistance is required for safe ambulation and ~~client~~Member is unable to maintain balance or to bear weight reliably; or

3) ~~Client~~Member has not been deemed independent with assistive devices ordered by a qualified ~~physician~~ Physician or Allowed Practitioner.

iii) Special Considerations: Ambulation shall not be a sole reason for a CNA visit.

b. Bathing/Showering

i) Task includes either:

1) Preparation for bath or shower, checking water temperature; assisting ~~client~~Member into bath or shower; applying soap and shampoo; rinsing off, towel drying; and all transfers and ambulation related to bathing; all hair care, pericare and skin care provided in conjunction with bathing; or

2) Bed bath or sponge bath.

~~ii) The usual frequency of this task shall be up to one time daily~~

~~i~~iii) Bathing/Showering is a skilled task when either:

1) Open wound(s), stoma(s), broken skin or active chronic skin disorder(s) are present; or

2) ~~Client~~Member is unable to maintain balance or to bear weight due to illness, injury, disability, a history of falls, temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

~~i~~iii~~v~~) Special Considerations:

1) Additional baths may be warranted for treatment and shall be documented by ~~physician~~ Physician or Allowed Practitioner order and Plan of Care.

2) A second person may be staffed when required to safely bathe the ~~client~~Member.

3) Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~Member in Activities of Daily Living when there has been a change in the ~~client~~Member's medical condition that has increased the ~~client~~Member's ability to perform this task.

c. Bladder Care

i) Task includes:

1) Assistance with toilet, commode, bedpan, urinal, or diaper;

2) Transfers, skin care, ambulation and positioning related to bladder care; and

3) Emptying and rinsing commode or bedpan after each use.

ii) Bladder Care concludes when the ~~client~~Member is returned to a pre-urination state.

iii) Bladder Care is a skilled task when either:

1) ~~Client~~Member is unable to assist or direct care, broken skin or recently healed skin breakdown (less than 60 days); or

2) ~~Client~~Member requires skilled skin care associated with bladder care or ~~client~~Member has been assessed as having a high and ongoing risk for skin breakdown.

d. Bowel Care

i) Task includes:

1) Changing and cleaning incontinent ~~client~~Member, or hands on assistance with toileting; and

2) Returning ~~client~~Member to pre-bowel movement status, which includes transfers, skin care, ambulation and positioning related to bowel care.

ii) Bowel care is a skilled task when either:

1) ~~Client~~Member is unable to assist or direct care, broken skin or recently healed skin breakdown (less than 60 days) is present; or

2) ~~Client~~Member requires skilled skin care associated with bowel care or ~~client~~Member has been assessed as having a high and ongoing risk for skin breakdown.

e. Bowel Program

i) Skilled Task includes:

1) Administering bowel program as ordered by the ~~client~~Member's qualified ~~physician~~ Physician or Allowed Practitioner, including digital stimulation, administering enemas, suppositories, and returning ~~client~~Member to pre-bowel program status; or

2) Care of a colostomy or ileostomy, which includes emptying the ostomy bag, changing the ostomy bag and skin care at the site of the ostomy and returning the ~~client~~Member to pre-procedure status.

ii) Special Considerations

1) To perform the task, the ~~client~~Member must have a relatively stable or predictable bowel program/condition and a qualified ~~physician~~ Physician or Allowed Practitioner deems that the CNA is competent to provide the ~~client~~Member-specific program.

2) Use of digital stimulation and over-the-counter suppositories or over-the-counter enema (not to exceed 120ml) only when the CNA demonstrates competence in the Home Health Agency's Policies & Procedures for the task. (Agencies may choose to delegate this task to the CNA.)

f. Catheter Care

i) Task includes:

1) Care of external, Foley and Suprapubic catheters;

2) Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care;

3) Emptying catheter bags; and

4) Transfers, skin care, ambulation and positioning related to the catheter care.

~~ii) The usual frequency of this task shall not exceed two times daily.~~

~~iiii~~) Catheter care is a skilled task when either:

1) Emptying catheter collection bags (indwelling or external) includes a need to record and report the ~~client~~Member's urinary output to the ~~client~~Member's nurse; or

2) The indwelling catheter tubing needs to be opened for any reason and the ~~client~~Member is unable to do so independently.

~~iiiv~~) Special Considerations: Catheter care shall not be the sole purpose of the CNA visit.

g. Dressing

i) Task includes:

1) Dressing and undressing with ordinary clothing, including pantyhose or socks and shoes;

2) Placement and removal of braces and splints; and

3) All transfers and positioning related to dressing and undressing.

~~ii) The usual frequency of this task shall not exceed twice daily.~~

iiii) Dressing is a skilled task when:

1) ClientMember requires assistance with the application of anti-embolic or pressure stockings and placement of braces or splints that can be obtained only with a prescription from a qualified physician Physician or Allowed Practitioner; or

2) ClientMember is unable to assist or direct care; or

3) ClientMember experiences a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

iiiiv) Special Considerations: Hand-over-hand assistance may be utilized for short term (up to 90 days) training of the clientMember in Activities of Daily Living when there has been a change in the clientMember's medical condition that has increased the clientMember's ability to perform this task.

h. Exercise/Range of Motion (ROM)

i) Task includes: ROM and other exercise programs prescribed by a therapist or qualified physician Physician or Allowed Practitioner, and only when the clientMember is not receiving exercise/ROM from a therapist or a doctor on the same day.

ii) Exercise/Range of Motion (ROM) is a skilled task when: The exercise/ROM, including passive ROM, is prescribed by a qualified physician Physician or Allowed Practitioner and the CNA has demonstrated competency.

iii) Special Considerations: The Home Health Agency shall ensure the CNA is trained in the exercise program. The Home Health Agency shall maintain the exercise program documentation in the clientMember record and it shall be evaluated/renewed by the qualified physician Physician or Allowed Practitioner or therapist with each Plan of Care.

i. Feeding

i) Task includes:

1) Ensuring food is the proper temperature, cutting food into bite-size pieces, and ensuring the food is proper consistency;

2) Placing food in clientMember's mouth; and

3) A Home Health Agency may allow a Certified Nursing Assistant (CNA) to administer feedings via tube, gravity, syringe and/or pump including gastrostomy-tube and jejunostomy-tube feeding for members with stable health conditions and are not considered high risk if the CNA is deemed competent.

3) Gastric tube (g-tube) formula preparation, verifying placement and patency of tube, administering tube feeding and flushing tube

~~following feeding if the Home Health Agency and supervising nurse deem the CNA competent.~~

ii) The usual frequency of this task shall not exceed ~~three times daily~~what is ordered by the Physician or Allowed Practitioner.

iii) Feeding is a skilled task when:

1) ~~Client~~Member is unable to communicate verbally, non-verbally or through other means;

2) ~~Client~~Member is unable to be positioned upright;

3) ~~Client~~Member is on a modified texture diet;

4) ~~Client~~Member has a physiological or neurogenic chewing or swallowing problem;

5) ~~Client~~Member is on mechanical ventilation;

6) ~~Client~~Member requires oral suctioning;

7) A structural issue (such as cleft palate) or other documented swallowing issues are present; or

8) ~~Client~~Member has a history of choking or aspirating on food. ~~has a history of aspirating food.~~

iv) Special Considerations:

1) There shall be a documented decline in medical condition or an ongoing need documented in the ~~client~~Member's record.

2) Consistent with Section 12-255-206, C.R.S., a~~A~~ Home Health Agency may allow a competent CNA to perform a syringe feeding, ~~and tube feeding if the~~ gastrostomy-tube, and jejunostomy-tube feeding for members with stable health conditions and ~~are~~ not considered high risk. ~~if the CNA is deemed competent~~ by the Home Health Agency.

j. Hygiene – Hair Care/Grooming

i) Task includes: Shampooing, conditioning, drying, and combing.

~~ii) Task does not include perming, hair coloring, or other extensive styling including, but not limited to, updos, placement of box braids or other elaborate braiding or placing hair extensions.~~

ii~~i~~) Task may be completed during skilled bath/shower.

~~iv) The usual frequency of this task shall not exceed twice daily.~~

iii) Hygiene – Hair Care/Grooming is a skilled task when:

1) ~~Client~~Member is unable to complete task independently;

2) ~~Client~~Member requires shampoo/conditioner that is prescribed by a qualified ~~physician~~ Physician or Allowed Practitioner and dispensed by a pharmacy; or

3) ~~Client~~Member has open wound(s) or stoma(s) on the head.

iv~~vi~~) Special Considerations:

1) Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~Member in Activities of Daily Living when there has been a change in the ~~client~~Member's medical condition that has increased the ~~client~~Member's ability to perform this task.

2) Styling of hair is never considered a skilled task.

k. Hygiene – Mouth Care

i) Task includes:

1) Brushing teeth;

2) Flossing;

3) Use of mouthwash;

4) Denture care;

5) Swabbing (toothette); or

6) Oral suctioning.

~~ii) The usual frequency of this task is up to three times daily.~~

iii~~ii~~) Hygiene – Mouth Care is a skilled task when:

1) ~~Client~~Member is unconscious;

2) ~~Client~~Member has difficulty swallowing;

3) ~~Client~~Member is at risk for choking and aspiration;

4) ~~Client~~Member requires oral suctioning;

5) ~~Client~~Member has decreased oral sensitivity or hypersensitivity; or

6) ~~Client~~Member is on medications that increase the risk of bleeding of the mouth.

iii~~iv~~) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~Member in Activities of

Daily Living when there has been a change in the ~~client~~Member's medical condition that has increased the ~~client~~Member's ability to perform this task.

l. Hygiene – Nail Care

i) Task includes: Soaking, filing, and nail trimming.

~~ii) The usual frequency of this task shall not exceed one time weekly.~~

iii~~ii~~) Hygiene – Nail Care is a skilled task when:

1) The ~~client~~Member has a medical condition that involves peripheral circulatory problems or loss of sensation;

2) The ~~client~~Member is at risk for bleeding; or

3) The ~~client~~Member is at high risk for injury secondary to the nail care.

iii~~iv~~) Nail Care shall only be completed by a CNA who has been deemed competent in nail care by the Home Health Agency for this population.

iv~~v~~) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~Member in Activities of Daily Living when there has been a change in the ~~client~~Member's medical condition that has increased the ~~client~~Member's ability to perform this task.

m. Hygiene – Shaving

i) Task includes: shaving of face, legs and underarms with manual or electric razor.

ii) ~~The usual frequency of this task shall not exceed once daily; T~~task may be completed with bathing/showering.

iii) Hygiene – Shaving is a skilled task when:

1) The ~~client~~Member has a medical condition involving peripheral circulatory problems;

2) The ~~client~~Member has a medical condition involving loss of sensation;

3) The ~~client~~Member has an illness or takes medications that are associated with a high risk for bleeding; or

4) The ~~client~~Member has broken skin at/near shaving site or a chronic active skin condition.

iv) Special Considerations: Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~Member in Activities of Daily Living when there has been a change in the ~~client~~Member's

medical condition that has increased the ~~client~~Member's ability to perform this task.

n. Meal Preparation

i) Task includes:

1) Preparation of food, ensuring food is proper consistency based on the ~~client~~Member's ability to swallow food safely; or

2) Formula preparation.

~~ii) The usual frequency of this task shall not exceed three times daily.~~

~~i~~iii~~i~~) Meal Preparation is a skilled task when: ~~Client~~Member's diet requires either nurse oversight to administer correctly, or meals requiring a modified consistency.

o. Medication Reminders

i) Task includes:

1) Providing ~~client~~Member reminders that it is time to take medications;

2) Handing of pre-filled medication box to ~~client~~Member;

3) Handing of labeled medication bottle to ~~client~~Member; or

4) Opening of prefilled box or labeled medication bottle for ~~client~~Member.

ii) This task may be completed by a CNA during the course of a visit but cannot be the sole purpose of the visit.

~~iii) A CNA may not perform this task, unless the CNA meets the DORA-approved CNA-MED certification, at 3 C.C.R. § 716-1 Chapter 19 Section 6. If the CNA does not meet the DORA certifications, the CNA may still ask if the client has taken medications and may replace oxygen tubing and may set oxygen to ordered flow rate.~~

~~iii~~iv~~)~~ Special Considerations: CNAs shall not administer medications without obtaining the CNA-MED certification from the DORA approved course. 3 C.C.R. 716-1 Chapter 19 Section 6. If the CNA has obtained this certification, the CNA may perform pre-pouring and medication administration within the scope of CNA-MED certification at 3 C.C.R. 716-1 Chapter 19 Section 3.

p. Positioning

i) Task includes:

1) Moving the ~~client~~Member from the starting position to a new position while maintaining proper body alignment and support to a ~~client~~Member's extremities, and avoiding skin breakdown; and

2) Placing any padding required to maintain proper alignment.

3) Positioning as a stand-alone task excludes positioning that is completed in conjunction with other Activities of Daily Living.

4) Positioning the Member requires adjusting the Member's alignment or posture in a bed, wheelchair, other furniture, assistive devices, or Durable Medical Equipment that has been ordered by a qualified Physician or Allowed Practitioner.

ii) Positioning is a skilled task when:

1) ~~Client~~Member is unable to communicate verbally, non-verbally or through other means;

2) ~~Client~~Member is not able to perform this task independently due to illness, injury or disability; or

3) ~~Client~~Member has temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability.

~~4) Positioning the client requires adjusting the client's alignment or posture in a bed, wheelchair, other furniture, assistive devices, or Durable Medical Equipment that has been ordered by a qualified physician.~~

iii) Special Considerations:

1) The Home Health Agency shall coordinate visits to ensure that effective scheduling is utilized for skilled Intermittent visits.

2) Positioning cannot be the sole reason for a visit.

q. Skin Care

i) Task includes:

1) Applying lotion or other skin care product, when it is not performed in conjunction with bathing or toileting tasks.

ii) Skin care is a skilled task when:

1) ~~Client~~Member requires additional skin care that is prescribed by a qualified ~~physician~~ Physician or Allowed Practitioner or dispensed by a pharmacy;

2) ~~Client~~Member has broken skin; or

3) ~~Client~~Member has a wound(s) or active skin disorder and is unable to apply product independently due to illness, injury or disability.

iii) Special Considerations:

1) Hand over hand assistance may be utilized for short term (up to 90 days) training of the ~~client~~Member in Activities of Daily Living when there has been a change in the ~~client~~Member's medical condition that has increased the ~~client~~Member's ability to perform this task.

2) This task may be included with positioning.

r.Transfers

i) Task includes:

1) Moving the ~~client~~Member from one location to another in a safe manner.

ii) It is not considered a separate task when a transfer is performed in conjunction with bathing, bladder care, bowel care or other CNA task.

iii) Transfers is a skilled task when:

1) ~~Client~~Member is unable to communicate verbally, non-verbally or through other means;

2) ~~Client~~Member is not able to perform this task independently due to fragility of illness, injury or disability;

3) ~~Client~~Member has a temporary lack of mobility due to surgery or other exacerbation of illness, injury or disability;

4) ~~Client~~Member lacks the strength and stability to stand or bear weight reliably;

5) ~~Client~~Member is not deemed independent in the use of assistive devices or Durable Medical Equipment that has been ordered by a qualified ~~physician~~ Physician or Allowed Practitioner; or

6) ~~Client~~Member requires a mechanical lift for safe transfers. In order to transfer ~~client~~Members via a mechanical lift, the CNA shall be deemed competent in the particular mechanical lift used by the ~~client~~Member.

iv) Special Considerations:

1) A second person may be used when required to safely transfer the ~~client~~Member.

2) Transfers may be completed with or without mechanical assistance.

3) Any unskilled task which requires a skilled transfer shall be considered a skilled task.

s.Vital Signs Monitoring

i) Task includes:

1) Taking and reporting the temperature, pulse, blood pressure and respiratory rate of the ~~client~~Member.

2) Blood glucose testing and pulse oximetry readings only when the CNA has been deemed competent in these measures.

ii) Vital sign monitoring is always a skilled task.

iii) Special Considerations:

1) ~~Shall only be performed when delegated by the client's nurse.~~ Vital signs monitoring cannot be the sole purpose of the CNA visit.

2) Vital signs shall be taken only as ordered by the ~~client~~Member's nurse or the Plan of Care and shall be reported to the nurse in a timely manner.

3) The CNA shall not provide any intervention without the nurse's direction, and may only perform interventions that are within the CNA practice act and for which the CNA has demonstrated competency.

13. Certified Nurse Aide Limitations

a. In accordance with the Colorado Nurse Aide Practice Act, a CNA shall only provide services that have been ordered on the Home Health Plan of Care as written by the ~~Ordering~~ Physician or Allowed Practitioner.

b. CNAs assist with Activities of Daily Living and cannot perform a visit for the purpose of behavior modification. When a ~~client~~Member's disabilities involve behavioral manifestations, the CNA shall follow all applicable behavioral plans and refrain from actions that will escalate or upset the ~~client~~Member. In such cases the guardian, case manager, behavioral professional or mental health professional shall provide clear direction to the agency for the provision of care. The CNA shall not perform Behavioral Interventions, beyond those listed in c. of this section.

c. If the ~~client~~Member has a behavior plan created by a behavior or mental health professional, the CNA shall follow this plan within their scope and training to the same extent that a family ~~client~~Member or paraprofessional in a school would be expected to follow the plan.

d. When an agency allows a CNA to perform skilled tasks that require competency or delegation, the agency shall have policies and procedures regarding its process for determining the competency of the CNA. All competency testing and documentation related to the CNA shall be retained in the CNA's personnel file.

e. CNA services can only be ordered when the task is outside of the usual responsibilities of the ~~client~~Member's ~~family member/caregiver~~ Family/In-Home Caregiver.

f. Cuing or hand over hand assistance to complete Activities of Daily Living is not considered a skilled task, however, the agency may provide up to 90 days of care to teach a ~~client~~Member Activities of Daily Living when the ~~client~~Member is able to learn to perform the tasks independently. Cuing or hand over hand care that exceeds 90 days or is provided when the ~~clien~~Member has not had a change in ability to complete self-care techniques, is not covered. If continued cuing or hand over hand assistance is required after 90 days, this task shall be transferred to a Personal Care Worker or other competent individual who can continue the task.

g. Personal care needs or skilled CNA services that are the contracted responsibility of an ALR~~F~~, GRSS or IRSS are not reimbursable as a separate Medicaid Home Health Service.

h. ~~Family members/caregivers~~ Family/In-Home Caregiver who meet all relevant requirements may be employed as a ~~client~~Member's CNA but may only provide services that are identified in this benefit coverage standard as skilled CNA services and that exceed the usual responsibilities of the ~~family member/caregiver~~ Family/In-Home Caregiver. ~~Family member/caregiver~~ Family/In-Home Caregiver CNAs must meet all CNA requirements.

i. All CNAs who provide Home Health Services shall be subject to all requirements set forth by the policies of the Home Health Agency, and all applicable State and Federal laws.

j. When a CNA holds other licensure(s) or certification(s), but is employed as or functions as a CNA, the services are reimbursed at the CNA rate for services.

k. CNA visits cannot be approved for, nor can extended units be billed for the sole purpose of completing personal care, homemaking tasks or instrumental Activities of Daily Living.

l. Personal care needs for ~~client~~Members ages ~~twenty~~ 20 years and under, not directly related to a skilled care task, shall be addressed through Section 8.535, Pediatric Personal Care~~PEDIATRIC PERSONAL CARE~~.

m. Homemaker Services provided as directly related tasks secondary to skilled care during a skilled CNA visit shall be limited to the permanent living space of the ~~client~~Member. Such services are limited to tasks that benefit the ~~clien~~Member and are not for the primary benefit of other persons living in the home.

n. Nursing or CNA visits, or requests for extended visits, for the sole purpose of Protective Oversight are not reimbursable by Medicaid.

o. CNA services for the sole purpose of providing personal care or homemaking services are not covered.

p. The Department does not reimburse for services provided by two CNAs to the same ~~client~~Member at the same time, except when two CNAs are required for transfers, there are no other persons available to assist, and the reason why

adaptive equipment cannot be used instead is documented in the Plan of Care. For this exception, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

q. The basic unit of reimbursement for CNA services is up to 60 minutes~~one hour~~. A unit of time that is less than~~fifteen~~ 15 minutes cannot be reimbursed as a basic unit.

r. For CNA visits that last longer than one-hour, extended units may be billed in addition to the basic unit. Extended units shall be increments of ~~fifteen~~ 15 minutes up to 30 minutes~~one-half hour~~. Any unit of time that is less than ~~fifteen~~ 15 minutes cannot be reimbursed as an extended unit.

14. Certified Nurse Aide (CNA) Supervision

a. CNA services shall be supervised by a registered nurse, by the physical therapist, or when appropriate, the speech therapist or occupational therapist depending on the specific Home Health Services the ~~client~~Member is receiving.

b. If the ~~client~~Member receiving CNA services is also receiving S~~s~~killed N~~n~~ursing care or physical therapy or occupational therapy, the supervising registered nurse or therapist shall make supervisory visits to the ~~client~~Member's home no less frequently than every 14 days. The CNA does not have to be present for every supervisory visit. However, the registered nurse, or the therapist shall make on-site supervisory visits to observe the CNA in the ~~client~~Member's home at least every 60 days.

c. If the ~~client~~Member is only receiving CNA services, the supervising registered nurse or the physical therapist shall make on-site supervisory visits to observe the CNA in the ~~client~~Member's home at least every 60 days.

d. The Department does not reimburse for any visit made solely for the purpose of supervising the CNA.

e. For all ~~client~~Members expected to require CNA services for at least a year, during supervisory visits the supervising nurse shall:

i) Obtain input from the ~~client~~Member, or the ~~client~~Member's designated representative into the Certified Nurse Aide Assignment Form, including all CNA tasks to be performed during each scheduled time period.

ii) Document details, duties, and obligations on the Certified Nurse Aide Assignment Form.

iii) Assure the Certified Nurse Aide Assignment Form contains information regarding special functional limitations and needs, safety considerations, special diets, special equipment, and any other information pertinent to the care to be provided by the CNA.

iv) Obtain the ~~client~~Member's, or the ~~client~~Member's authorized representative's ~~, per section 8.520.7.E.1,~~ signature on the Certified Nurse Aide Assignment Form ~~form~~, and provide a copy to the ~~client~~Member at the beginning of services, and at least once per year

thereafter. A new copy of the Written Notice of Home Care Consumer Rights form, per Ssection 8.520.7.E.1, shall also be provided at these times.

v) Explain the rights listed in the patient's rights form whenever the Certified Nurse Aide Assignment Form is renegotiated and rewritten.

vi) For purposes of complying with this requirement, once per year means a date within one year of the prior certification.

15. If a Member does not meet the factors that make a task skilled, as outlined in Section 8.520.5.B.12., the Member may be eligible to receive those services as unskilled personal care through Section 8.7538, Home and Community Based Services, Personal Care. ~~If a client does not meet the factors that make a task skilled, as outlined in Section 8.520.5.B.125., the client may be eligible to receive those services as unskilled personal care through Section 8.535, PEDIATRIC PERSONAL CARE, or Section 583008.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE-EBD.~~

8.520.5.C. Therapy Services

1. Therapies are only covered:

a. In acute home health care; or

b. ~~Client~~Members 20 years of age or younger may receive long-term home health therapy when services are medically necessary.

c. When the ~~client~~Member's ~~Ordering Practitioner~~ Physician or Allowed Practitioner prescribes therapy services, and the therapist is responsible for evaluating the ~~client~~Member and creating a treatment plan with exercises in accordance with practice guidelines.

2. The therapist shall teach the ~~client~~Member, the ~~client~~Member's ~~family member/caregiver~~ Family/In-Home Caregiver and other ~~client~~Members of the Home Health care team to perform the exercises as necessary for an optimal outcome.

3. When the therapy Plan of Care includes devices and equipment, the therapist shall assist the ~~client~~Member in initiating or writing the request for equipment and train the ~~client~~Member on the use of the equipment.

4. Home Health Agencies shall only provide physical, occupational, or speech therapy services when:

a. Improvement of functioning is expected or continuing;

b. The therapy assists in overcoming developmental problems;

c. Therapy visits are necessary to prevent deterioration;

d. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration, and to teach CNAs or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; or

e. Therapy visits are indicated to assess the safety or optimal functioning of the ~~client~~Member in the home, or to train in the use of equipment used in implementation of the therapy Plan of Care.

5. Physical Therapy

a. Physical therapy includes any evaluations and treatments allowed under state law at C.R.S. § 12- 41-101 through 130, which are applicable to the home setting.

b. When devices and equipment are indicated by the therapy Plan of Care, the therapist shall assist in initiating or writing the request in accordance with Sections 8.590 through 8.590.7.P.~~Sections 8.590 through 8.594.03~~, Durable Medical Equipment, ~~,~~ and shall assist in training on the use of the equipment.

c. Treatment must be provided by or under the supervision of a licensed physical therapist who meets the qualifications prescribed by federal regulation for participation in Medicare ~~, at 42 CFR 484.4;~~ and who meets all requirements under state law. ~~Title 42 of the Code of Federal Regulations, Part 484.4 (2013) 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. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.~~

i) Physical therapy assistants (PTA) can render Home Health therapy but shall practice under the supervision of a registered physical therapist.

d. For ~~client~~Members who do not require S~~s~~killed N~~n~~ursing care, the physical therapist may open the case and establish the Plan of Care.

e. Physical therapists are responsible for completing ~~client~~Member assessments related to various physical skills and functional abilities.

f. Physical therapy includes evaluations and treatments allowed under state law and is available to all acute home health ~~client~~Members and pediatric long-term Home Health ~~client~~Members. Therapy plans and assessments shall contain the therapy services requested; the specific procedures and modalities to be used, including amount, duration, and frequency; and specific goals of therapy service provision.

g. Limitations

i) Physical therapy for ~~client~~Members ages 21 or older is not covered for acute care needs when treatment becomes focused on maintenance, and no further functional progress is apparent or expected to occur.

ii) Physical therapy is not a benefit for adult long-term home health ~~client~~Members. ~~Client~~Members 20 years of age or younger may receive Long-Term Home Health therapy services when services are medically necessary.

iii) ~~Client~~Members ages 21 and older who continue to require therapy after the acute home health period may obtain long-term therapy services in an outpatient setting. ~~Client~~Members shall not be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.

iv) ~~Client~~Members 20 years of age or younger may obtain therapy services for maintenance care through acute home health and through long-term home health.

v) Physical therapy visits for the sole purpose of providing massage or ultrasound are not covered.

vi) Medicaid does not reimburse for two physical therapists during one visit.

vii) The unit of reimbursement for physical therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~Member care or treatment.

6. Occupational Therapy

a. Occupational therapy includes evaluations and treatments allowed under the standards of practice authorized by the American Occupational Therapy Association, which are applicable to the home setting.

b. When devices and equipment are indicated by the therapy Plan of Care, the therapist shall assist in initiating or writing the request and shall assist in training the ~~client~~Member on the use of the equipment.

c. Treatment shall be provided by or under the supervision of a registered occupational therapist who meets the qualifications prescribed by federal regulations for participation under applicable federal and state laws, including Medicare requirements at 42 CFR § 484.4.

i) Occupational therapy assistants (OTA) can render Home Health therapy but shall practice under the supervision of a registered occupational therapist.

d. For ~~client~~Members who do not require S~~s~~killed N~~n~~ursing care, the occupational therapist may open the case and establish the Plan of Care.

e. Occupational therapy includes only evaluations and treatments that are allowed under state law for occupational therapists.

f. Occupational therapists shall create a plan and perform assessments which state the specific therapy services requested, the specific procedures and modalities to be used, the amount, duration, frequency, and the goals of the therapy service provision.

g. Limitations

i) Occupational therapy for ~~client~~Members ages 21 or older is not a benefit under acute Home Health Services when treatment becomes maintenance, and no further functional progress is apparent or expected to occur.

ii) Occupational therapy is not a benefit for adult long-term home health ~~client~~Members.

iii) ~~Client~~Members ages 21 and older who continue to require therapy after the acute home health period may only obtain long-term therapy services in an outpatient setting.

iv) ~~Client~~Members shall not be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.

v) ~~Client~~Members 20 years of age or younger may continue to obtain therapy services for maintenance care in acute home health and in long-term home health.

vi) Medicaid does not reimburse for two occupational therapists during one visit.

vii) The unit of reimbursement for occupational therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~Member care or treatment.

7. Speech Therapy

a. Speech therapy services include any evaluations and treatments allowed under the American Speech-Language-Hearing Association (ASHA) authorized scope of practice statement, which are applicable to the home setting.

b. When devices and equipment are indicated by the therapy Pp~~p~~lan of Cc~~c~~are, the therapist shall assist in initiating or writing the request in accordance with Sections 8.590 through 8.590.7.P.~~Sections 8.590 through 8.594.03~~, Durable Medical Equipment, and shall assist in training on the use of the equipment.

c. Treatment must be provided by a speech/language pathologist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR § 484.4.

d. For ~~client~~Members who do not require Ss~~s~~killed Nn~~r~~ursing care, the speech therapist may open the case and establish the Medicaid Pp~~p~~lan of Cc~~c~~are.

e. The speech/language pathologist shall state the specific therapy services requested, the specific procedures and modalities to be used, as well as the amount, duration, frequency and specific goals of therapy services on the Plan of Care.

f. Limitations

i) Speech therapy for ~~client~~Members ages 21 or older is not a benefit under acute Home Health Services when treatment becomes maintenance, and no further functional progress is apparent or expected to occur.

ii) ~~Client~~Members cannot be moved to acute home health for the sole purpose of continuing therapy services from a previous acute home health care episode.

iii) Speech therapy is not a benefit for adult long-term home health ~~client~~Members.

iv) Treatment of speech and language delays is only covered when associated with a C~~c~~hronic M~~m~~edical C~~c~~ondition, neurological disorder, acute illness, injury, or congenital issue.

v) ~~Client~~Members 20 years of age or younger may continue to obtain therapy services for maintenance care in acute home health and in long-term home health.

vi) Medicaid does not reimburse for two speech therapists during one visit.

vii) The unit of reimbursement for speech therapy is one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in ~~client~~Member care or treatment.

8.520.5.D. ~~Home Health Telehealth Services~~Remote Patient Monitoring

1. The Home Health Agency shall create policies and procedures for the use and maintenance of the monitoring equipment and the process of ~~telehealth monitoring~~ Remote Patient Monitoring. This service shall be used to monitor the ~~client~~Member and manage the ~~client~~Member's care, and shall include all of the following elements:

   a. The ~~client~~Member's designated registered nurse or licensed practical nurse, consistent with state law, shall review all data collected within 24 hours of receipt of the ordered transmission, or in cases where the data is received after business hours, on the first business day following receipt of the data;

   b. The ~~client~~Member's designated nurse shall oversee all planned interventions;

   c. ~~Client~~Member-specific parameters and protocols defined by the agency staff and the ~~client~~Member's Physician or Allowed Practitioner ~~authorizing physician or podiatrist~~; and

   d. Documentation of the clinical data in the ~~client~~Member's chart and a summary of response activities, if needed.

      i) The nurse assessing the clinical data shall sign and date all documentation; and

      ii) Documentation shall include the health care data that was transmitted and the services or activities that are recommended based on the data.

2. The Home Health Agency shall provide monitoring equipment that possesses the capability to measure any changes in the monitored diagnoses, and meets all of the following requirements:

   a. Food and Drug Administration (FDA) certified or ~~UL~~ Underwriters Laboratory (UL) listed, and used according to the manufacturer's instructions;

   b. Maintained in good repair and free from safety hazards; and

   c. Sanitized before installation in a ~~client~~Member's home.

3. ~~Home Health Telehealth~~ Remote Patient Monitoring services are covered for ~~client~~Members receiving Home Health Services, when all of the following requirements are met:

   a. ~~Client~~Member receives services from a home health provider for at least one of the following diagnoses:

      i) Congestive Heart Failure;

      ii) Chronic Obstructive Pulmonary Disease;

      iii) Asthma;

      iv) Diabetes;

      v) Pneumonia; or

      vi) Other diagnosis or medical condition deemed eligible by the Department or its Designee.

   b. ~~Client~~Member requires ongoing and frequent monitoring, minimum of five times weekly, to manage their qualifying diagnosis as defined and ordered by a ~~physician~~ Physician or Allowed Practitioner or podiatrist;

   c. ~~Client~~Member has demonstrated a need for ongoing monitoring as evidenced by:

      i) Having been hospitalized or admitted to an emergency room two or more times in the last ~~twelve~~ 12 months for medical conditions related to the qualifying diagnosis;

      ii) If the ~~client~~Member has received Home Health Services for less than six months, the ~~client~~Member was hospitalized at least once in the last three months;

      iii) An acute exacerbation of a qualifying diagnosis that requires Remote Patient Monitoring;~~,~~ or

      iv) New onset of a qualifying disease that requires ongoing monitoring to manage the ~~client~~Member in their residence.

   d. ~~Client~~Member or caregiver misses no more than five transmissions of the provider and agency prescribed monitoring events in a ~~thirty~~ 30-~~-~~day period; and

e. ~~Client~~Member's home environment has the necessary connections to transmit the ~~telehealth~~ Remote Patient Monitoring data to the agency and has space to set up and use the equipment as prescribed.

4. The Home Health Agency shall make at least one home health nursing visit every 14 days to a ~~client~~Member using ~~Home Health Telehealth~~ Remote Patient Monitoring ~~services~~.

5. The Home Health Agency shall develop agency-specific criteria for assessment of the need for ~~Home Health Telehealth~~ Remote Patient Monitoring~~services~~, to include patient selection criteria, home environment compatibility, and patient competency. The agency shall complete these assessment forms prior to the submission of the enrollment application and they shall be kept on file at the agency.

6. The ~~client~~Member and/or caregiver shall comply with the ~~telehealth monitoring~~ Remote Patient Monitoring as ordered by the qualifying ~~physician~~ Physician or Allowed Practitioner.

7. Limitations:

a. ~~Client~~Members who are unable to comply with the ordered ~~telehealth monitoring~~ Remote Patient Monitoring shall be disenrolled from the services.

b. Services billed prior to obtaining approval to enroll a ~~client~~Member into ~~Home Health Telehealth~~ Remote Patient Monitoring ~~services~~ by the Department or its Designee are not a covered benefit.

c. The unit of reimbursement for ~~Home Health Telehealth~~ Remote Patient Monitoring is one calendar day.

i) The Home Health Agency may bill one initial installation unit per ~~client~~Member lifetime when the monitoring equipment is installed in the home.

ii) The Home Health Agency may bill the daily rate for each day the ~~telehealth monitoring~~ Remote Patient Monitoring equipment is used to monitor and manage the ~~client~~Member's care.

d. Once per lifetime per ~~client~~Member, a Home Health Agency may bill for the installation of the ~~Home Health Telehealth~~ Remote Patient Monitoring equipment.

8.520.6 Supplies

8.520.6.A. Reimbursement for routine supplies is included in the reimbursement for nursing, CNA, physical therapy, occupational therapy, and speech therapy services. Routine supplies are supplies that are customarily used during the course of home care visits. These are standard supplies utilized by the Home Health Agency staff and not designated for a specific ~~client~~Member.

8.520.6.B. Non-routine supplies may be a covered benefit when approved by the Department or its Designee.

8.520.6.C. Limitations

1. A Home Health Agency cannot require a ~~client~~Member to purchase or provide supplies that are necessary to carry out the ~~client~~Member's Plan of Care.

2. A ~~client~~Member may opt to provide his or her own supplies.

8.520.7. Documentation

8.520.7.A. Home Health Agencies shall have written policies regarding delegation of tasks by nurses ~~delegation~~.

8.520.7.B. Home Health Agencies shall have written policies regarding maintenance of ~~client~~Members' durable medical equipment and make full disclosure of these policies to all ~~client~~Members with durable medical equipment in the home. The Home Health Agency shall provide such disclosure to the ~~client~~Member at the time of intake.

8.520.7.C. Home Health Agencies shall have written policies regarding procedures for communicating with case managers of ~~client~~Members who are also enrolled in HCBS programs. Such policies shall include, at a minimum:

1. How agencies will inform case managers that services are being provided or are being changed; and

2. Procedures for sending copies of Plans of Care if requested by case managers. These policies shall be developed with input from case managers.

8.520.7.D. **Plan of Care Requirements**

1. The ~~client~~Member's ~~Ordering Practitioner~~ Physician or Allowed Practitioner shall order Home Health Services in writing, as part of a written Plan of Care. The written Plan of Care shall be reviewed and updated every 60 calendar days but need not be provided to the Department or its Designee unless the ~~client~~Member's status has changed significantly, a new PAR is needed, or if requested by the Department or its Designee.

2. The initial assessment or continuation of care assessments shall be completed by a registered nurse, or by a physical therapist, occupational therapist or speech therapist when no S~~s~~killed N~~n~~ursing needs are required. The assessment shall be utilized to develop the Plan of Care with provider input and oversight. The written Plan of Care and associated documentation shall be used to complete the CMS-485 ~~(or a document that is identical in content)~~ Plan of Care, or a form that is of similar format to the CMS-485 and shall include:

   a. Identification of the ~~Ordering Practitioner;~~ Physician or Allowed Practitioner;

   b. ~~Ordering Practitioner~~ Physician or Allowed Practitioner orders;

   c. Identification of the specific diagnoses, including the primary diagnosis, for which Medicaid Home Health Services are requested.

   d. The specific circumstances, ~~client~~Member medical condition(s) or situation(s) that require services to be provided in the ~~client~~Member's residence rather than in a ~~Ordering~~ Physician or Allowed Practitioner's office, clinic or other outpatient setting including the availability of natural supports and the ~~client~~Member's living situation;

e. A complete list of supplements, and medications, both prescription and over the counter, along with the dose, the frequency, and the means by which the medication is taken;

f. A complete list of the ~~client~~Member's allergies;

g. A list of all non-routine durable medical equipment used by the ~~client~~Member;

h. A list of precautions or safety measures in place for the ~~client~~Member, as well as functional limitations or activities permitted by the ~~client~~Member's ~~-~~Physician or Allowed Practitioner ~~qualified physician~~;

i. A behavioral plan when applicable. Physical Behavioral Interventions, such as restraints, shall not be included in the home health Plan of Care;

j. A notation regarding the ~~client~~Member's ~~Ordering~~ Physician or Allowed Practitioner-ordered dietary (nutritional) requirements and restrictions, any special considerations, other restrictions or nutritional supplements;

k. The Home Health Agency shall indicate a comprehensive list of the amount, frequency, and expected duration of provider visits for each discipline ordered by the ~~client~~Member's ~~Ordering~~ Physician or Allowed Practitioner, including:

i) The specific duties, treatments and tasks to be performed during each visit;

ii) All services and treatments to be provided on the Plan of Care;

1) Treatment plans for physical therapy, occupational therapy and speech therapy may be completed on a form designed specifically for therapy Plans of Care; and

iii) Specific situations and circumstances that require a PRN visit, if applicable.

l. Current clinical summary of the ~~client~~Member's health status, including mental status, and a brief statement regarding homebound status of the ~~client~~Member;

m. The ~~client~~Member's prognosis, goals, rehabilitation potential and where applicable, the ~~client~~Member's specific discharge plan;

i) If the ~~client~~Member's illness, injury or disability is not expected to improve, or discharge is not anticipated, the agency is not required to document a discharge plan;

ii) The ~~client~~Member's medical record shall include the reason that no discharge plan is present;

n. The ~~Ordering Practitioner~~ Physician or Allowed Practitioner shall approve the Plan of Care with a dated signature. If an electronic signature is used, the agency shall document that an electronic signature was used and shall keep a copy of the ~~Ordering~~ Physician or Allowed Practitioner's physical signature on file;

o. Brief statement regarding the ~~client~~Member's support network including the availability of the ~~client~~Member's ~~family member/caregiver~~ Family/In-Home Caregiver and if applicable, information on why the ~~client~~Member's ~~family member/caregiver~~ Family/In-Home Caregiver is unable or unwilling to provide the care the ~~client~~Member requires; and

p. Other relevant information related to the ~~client~~Member's need for Home Health care.

3. A new Plan of Care shall be completed every 60 calendar days while the ~~client~~Member is receiving Home Health Services. The Plan of Care shall include a statement of review by the ~~Ordering Practitioner~~ Physician or Allowed Practitioner every 60 days.

4. Home Health Agencies shall send new Plans of Care and other documentation as requested by the Department or its Designee.

8.520.7.E. Additional Required ~~Client~~Member Chart Documentation

1. A signed copy of the Written Notice of Home Care Consumer Rights as required by the Department and at 42 CFR § 484.10. ~~Title 42 of the Code of Federal Regulations, Part 484.10 (2013) 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. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~;

2. Evidence of a face-to-face visit with the ~~client~~Member's referring provider, or other appropriate provider, as required at 42 CFR § 440.70. ~~Title 42 of the Code of Federal Regulations, Part 440.70 (2016) 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. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~;

3. A signed and dated copy of the Agency Disclosure Form as required by the Department, with requirements at 42 CFR § 484.12. ~~Title 42 of the Code of Federal Regulations, Part 484.12 (2013) 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. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule~~;

4. Dates of the most recent hospitalization or nursing facility stay. If the most recent stay was within the last 90 days, reason for the stay (diagnoses), length of stay, summary of treatment, date and place discharged to shall be included in the clinical summary or update;

5. The expected health outcomes, which may include functional outcomes;

6. An emergency plan including the safety measures that will be implemented to protect against injury;

7. A specific order from the ~~client~~Member's Physician or Allowed Practitioner ~~qualified physician~~ for all PRN visits utilized;

8. Clear documentation of skilled and non-skilled services to be provided to the ~~client~~Member with documentation that the ~~client~~Member or ~~client~~Member's ~~family member/caregiver~~ Family/In-Home Caregiver agrees with the Plan of Care;

9. Accurate and clear clinical notes or visit summaries from each discipline for each visit that include the ~~client~~Member's response to treatments and services completed during the visit. Summaries shall be signed and dated by the person who provided the service. If an electronic signature is used, the agency shall document that an electronic signature was used and keep a copy of the physical signature on file;

10. Documented evidence of Care Coordination with the ~~client~~Member's other providers;

11. When the ~~client~~Member is receiving additional services (skilled or unskilled) evidence of Care Coordination between the other services shall be documented and include an explanation of how the requested Home Health Services do not overlap with these additional services;

12. A plan for how the agency will cover ~~client~~Member services (via ~~family member/caregiver~~ Family/In-Home Caregiver or other agency staff) if inclement weather or other unforeseen incident prevents agency staff from delivering the Home Health care ordered by the Physician or Allowed Practitioner; and~~fied physician~~; and

13. If foot or wound care is ordered for the ~~client~~Member, the Home Health Agency shall ensure the signs and symptoms of the disease process/medical condition that requires foot or wound care by a nurse are clearly and specifically documented in the clinical record. The Home Health Agency shall ensure the clinical record includes an assessment of the foot or feet, or wound, and physical and clinical findings consistent with the diagnosis, and the need for foot or wound care to be provided by a nurse.

8.520.8 Prior Authorization

8.520.8.A. General Requirements

1. Approval of the PAR does not guarantee payment by Medicaid.

2. The ~~client~~Member and the HHA shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations.

3. Medicaid is always the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to only bill for Medicaid approved services to Medicare or other third-party insurance prior to billing Medicaid.

   a. Exceptions to this include Early Intervention Services documented on a child's Individualized Family Service Plan (IFSP) and the following services that are not

a skilled Medicare benefit (CNA services only, OT services only, Med-box pre-pouring and routine lab draws).

4. In the event a Member changes provider agencies, the receiving HHA shall submit a Change of Provider Form and POC to the URC within 10 business days of starting LTHH services.

8.520.8.B. Acute Home Health

1. Acute Home Health Services do not require prior authorization. This includes episodes of acute home health for L~~l~~ong-T~~t~~erm H~~h~~ome H~~h~~ealth ~~client~~Members. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

2. If a ~~client~~Member receiving L~~l~~ong-T~~t~~erm Home Health Services experiences an acute care event that necessitates moving the ~~client~~Member to an acute home health episode, the agency shall notify the Department or its Designee that the ~~client~~Member is moving from long-term home health to acute Home Health Services.

3. If the ~~client~~Member's acute home health needs resolve prior to 60 calendar days, the Home Health Agency shall discharge the ~~client~~Member, or submit a PAR for L~~l~~ong-T~~t~~erm Home Health Services if the Member is eligible.

   a. If an acute home health ~~client~~Member experiences a change in status (e.g. an inpatient admission), that totals ~~9~~nine calendar days or less, the Home Health Agency shall resume the ~~client~~Member's care under the current acute home health Plan of Care.

   b. If an acute home health ~~client~~Member experiences a change in status (e.g. an inpatient admission), that totals 10 calendar days or more, the Home Health Agency may start a new Acute Home Health episode when the ~~client~~Member returns to the Home Health Agency.

   c. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within 10 working days of the beginning and within 10 working days of the end of the acute care episode.

8.520.8.C. Long-Term Home Health

1. Long-T~~t~~erm Home Health Services ~~do not~~ require prior authorization. ~~under Section 8.017.E.~~

2. When an agency accepts an HCBS waiver ~~client~~Member to L~~l~~ong-T~~t~~erm Home Health Services, the Home Health Agency shall contact the ~~client~~Member's case management agency to inform the case manager of the ~~client~~Member's need for Home Health Services.

3. Long-Term Home Health Services ~~for all Members require prior authorization by the Department or its Designee. T~~require the completion of the Skilled Care Acuity Assessment ~~Acuity Tool~~ to reliably provide consistent information, and ~~that~~ is to be completed by the designated Nurse Assessor Vendor. The assessment results are a~~is~~ part of a body of evidence used to determine Medical Necessity but does not independently determine the outcomes of service eligibility.

43. The complete formal written PAR shall include:

a. A completed Department-prescribed Prior Authorization Request Form, see Section 8.058;

b. A home health Plan of Care, which includes all clinical assessments and current clinical summaries or updates of the ~~client~~Member. The Plan of Care shall be on the CMS-485 form, or a form that is of similar format ~~identical in content~~ to the CMS-485, and all sections of the form shall be completed. For ~~client~~Members 20 years of age or younger, all therapy services requested shall be included in the Plan of Care or addendum, which lists the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in Section 8.520.5.B.13.r.~~Section 8.520.9.B.~~ are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the Plan of Care and assessments may be completed by a therapist if the ~~client~~Member is 20 years of age or younger and is receiving home health therapy services;

c. For Members under 21 years of age, w~~W~~ritten documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the ~~client~~Member's third-party insurance;

d. Any other medical information which will document the M~~m~~edical N~~n~~ecessity for the Home Health Services. Support for Medical Necessity must be documented in the PAR submission to be considered in the PAR review and any subsequent appeal;

e If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a CNA visit;

f. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, evidence that the ~~client~~Member's pharmacy was contacted, and advised the Home Health Agency that the pharmacy will not provide medication set-ups, shall be documented; and

g. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, documentation supporting the current need for two-person transfers, and the reason adaptive equipment cannot be used instead, shall be provided.

h. Long-~~-~~Term Home Health Services for ~~client~~Members 20 years of age or younger require prior authorization by the Department or its Designee using the approved utilization management tool.

54. Authorization time frames:

a. PARs shall be submitted for and may be approved for up to a one-~~-~~year period.

b The Department or its Designee may initiate PAR revisions if the Plans of Care indicate significantly decreased services.

c. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the ~~CMS-485~~ CMS-485 Plan of Care, or a form that is of similar format to the CMS-485.

~~6~~5. The PAR shall not be backdated to a date prior to the 'from' date of the ~~CMS-485~~ CMS-485 Plan of Care, or a form that is of similar format to the CMS-485.

~~7~~6. The Department or its Designee shall approve or deny according to the following guidelines for safeguarding ~~client~~Members:

a. PAR Approval: If services requested are in compliance with Medicaid rules and are medically necessary and appropriate for the diagnosis and treatment plan, the services are approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

b. PAR Denial:

i) The Department or its Designee shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish M~~m~~edical N~~n~~ecessity (e.g., the PAR is not consistent with the ~~client~~Member's documented medical needs and functional capacity). Denials based on M~~m~~edical N~~n~~ecessity shall be determined by a registered nurse, ~~or physician~~ Physician or Allowed Practitioner.

ii) When denied or reduced, services shall be approved in accordance with Section 8.057.5.~~for 60 additional days after the date on which the notice of denial is mailed to the client, through August 31, 2022. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.~~

c. Interim Services: Services provided during the period between the provider's submission of the PAR form to the Department or its Designee, to the final approval or denial by the Department may be approved for payment. Payment may be made retroactive to the start date on the PAR form, or up to 30 working days, whichever is shorter.

i) If the PAR is denied and the Member appeals that denial, the Department will not be the proponent of an order regarding that denial solely by virtue of having provided interim services. The Member will maintain the burden of proof to establish eligibility for services requested in the PAR.

8.520.8.D. EPSDT Services

1. Home Health Services beyond those allowed in Section 8.520.5, for ~~client~~Members ~~ages 0 through 20~~under the age of 21, shall be reviewed for M~~m~~edical N~~n~~ecessity under the EPSDT requirement, as defined at Section 8.280.1.

2. Home Health Services beyond those in Section 8.520.5, which are provided under the Home Health benefit due to Mmedical Nnecessity, cannot include services that are available under other Colorado Medicaid benefits for which the ~~client~~Member is eligible, including, but not limited to, Private Duty Nursing, Section 8.540; Home and Community-Based Services (HCBS)~~HCBS Personal Care~~, Section 8.7000~~8.489~~; Pediatric Personal Care, Section 8.535; School Health and Related Services, Section 8.290, or Outpatient Therapies, Section 8.200.3.A.6, Section 8.200.5.B., and Section 8.200.3.D.2. ~~Section 8.200.3.A.6, Section 8.200.5 and Section 8.200.3.D~~ Exceptions may be made if EPSDT Home Health Services will be more cost-effective, provided that ~~client~~Member safety is assured. Such exceptions shall, in no way, be construed as mandating the delegation of nursing tasks.

3. PARs for EPSDT home health shall be submitted and reviewed as outlined in Section 8.520.8, including all documentation outlined in Section 8.520.8, and any other medical information which will document the Mmedical Nnecessity for the EPSDT Home Health Services. The Plan of Care shall include the place of service for each home health visit.

8.520.8.E. ~~**Home Health Telehealth Services**~~**Remote Patient Monitoring**

1. ~~Home Health Telehealth services~~ Remote Patient Monitoring requires prior authorization.

2. The ~~Home Health Telehealth~~ Remote Patient Monitoring PARs shall include all of the following:

   a. A completed enrollment form;

   b. An order for ~~telehealth monitoring~~ Remote Patient Monitoring signed and dated by the ~~Ordering Practitioner~~ Physician or Allowed Practitioner or podiatrist;

   c. A Plan of Care, which includes nursing and therapy assessments for ~~client~~Members. ~~Telehealth monitoring~~ Remote Patient Monitoring shall be included on the CMS-485~~form, or a form that contains identical information to the CMS-485,~~ Plan of Care, or a form that is of similar format to the CMS-485 and all applicable forms shall be complete; and

   d. For ongoing~~telehealth~~ Remote Patient Monitoring, the agency shall include documentation on how ~~telehealth~~ Remote Patient Monitoring data has been used to manage the ~~client~~Member's care, if the ~~client~~Member has been using ~~Home Health Telehealth services~~ Remote Patient Monitoring.

8.520.9 Reimbursement

8.520.9.A. ~~**Rates of Reimbursement:**~~ Payment for Home Health Services is the lower of the billed charges or the maximum unit rate of reimbursement.

1. The maximum reimbursement for any 24-~~-~~hour period, as measured from midnight to midnight, shall not exceed the daily maximum as designated by the Department and in alignment with the Legislative Budget.

2. The maximum daily reimbursement includes reimbursement for nursing visits, home health CNA visits, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof.

3. No individual Nurse (RN/LPN), Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), or Certified Nursing Assistant (CNA) may be reimbursed for more than 16 hours of care per day for one or more members collectively.

8.520.9.B. Special Reimbursement Conditions

1. Total reimbursement by the Department combined with third party liability and Medicare crossover claims shall not exceed Medicaid rates.

2. When Home Health Agencies provide Home Health Services in accordance with these regulations to ~~Client~~Members who receive Home and Community-based Services for the Developmentally Disabled (HCBS-DD), the Home Health Agency is reimbursed:

   a. Under normal procedures for home health reimbursement if the ~~Client~~Member resides in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)~~, or in IRSS host homes and settings~~; or

   b. By the group home provider, if the ~~Client~~Member resides in a GRSS, because the provider has already received Medicaid funding for the Home Health Services and is responsible for payment to the Home Health Agency.

3. Acute Home Health Services for Medicaid HMO ~~Client~~Members are the responsibility of the Medicaid HMO, including ~~Client~~Members who are also HCBS recipients.

4. Services for a dual eligible ~~Client~~Member shall be submitted first to Medicare for reimbursement. All Medicare requirements shall be met and administrative processes exhausted prior to any dual eligible ~~Client~~Member's claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except for the specific services listed in Section 8.520.0.E.4.a below for ~~Client~~Members which meet the criteria listed in Section 8.520.9.E.4.b below.

   a. A Home Health Agency may bill only Medicaid without first billing Medicare if both of the following are true:

      i) The services below are the only services on the claim:

         1) Pre-pouring of medications;

         2) CNA services;

         3) Occupational therapy services when provided as the sole skilled service; or

         4) Routine laboratory draw services.

      ii) The following conditions apply:

         1) The ~~Client~~Member is stable;

         2) The ~~Client~~Member is not experiencing an acute episode; and

         3) The ~~Client~~Member routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.

b. The Home Health Agency shall maintain clear documentation in the ~~Client~~Member's record of the conditions and services that are billed to Medicaid without first billing Medicare.

c. A Home Health Change of Care Notice or Advance Beneficiary Notice of Non-Coverage shall be filled out as prescribed by Medicare.

5. Services for a dually eligible long-term home health ~~Client~~Member who has an acute episode shall be submitted first to Medicare for reimbursement. Medicaid may be billed if payment is denied by Medicare as a non-covered benefit and the service is a Medicaid benefit, or when the service meets the criteria listed in Section 8.520.9.E.4 above.

6. If both Medicare and Medicaid reimburse for the same visit or service provided to a ~~Client~~Member in the same episode, the reimbursement is considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.

a. Home Health Agencies shall return any payment made by Medicaid for such visit or service to the Department within ~~sixty~~ 60 calendar days of receipt of the duplicate payment.

8.520.9.C. Reimbursement for Supplies

1. A Home Health Agency shall not ask a ~~Client~~Member to provide any supplies. A request for supplies from a ~~Client~~Member may constitute a violation of Section 8.012, providers prohibited from collecting payment from recipients. ~~PROVIDERS PROHIBITED FROM COLLECTING PAYMENT FROM RECIPIENTS.~~

2. Supplies other than those required for practice of universal precautions which are used by the Home Health Agency staff to provide Home Health Services are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the ~~physician~~ Physician or Allowed Practitioner as a benefit to the ~~Client~~Member under Section 8.590, ~~DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLES~~ Durable Medical Equipment and disposable medical supplies.

3. Supplies used for the practice of universal precautions by the ~~Client~~Member's ~~family or other informal caregivers~~ Family/In-Home Caregiver are not the financial responsibility of the Home Health Agency. Such supplies may be requested by the ~~physician~~ Physician or Allowed Practitioner as a benefit to the ~~Client~~Member under Section 8.590, ~~DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES~~ Durable Medical Equipment and disposable medical supplies.

8.520.9.D. Restrictions

1. When the ~~Client~~Member has Medicare or other third-party insurance, Home Health claims to Medicaid will be reimbursed only if the ~~Client~~Member's care does not meet the Home Health coverage guidelines for Medicare or other insurance.

2. When an agency provides more than one employee to render a service, in which one employee is supervising or instructing another in that service, the Home Health Agency shall only bill and be reimbursed for one employee's visit or units.

3. Any visit made by a nurse or therapist to simultaneously serve two or more ~~Client~~Members residing in the same household shall be billed by the Home Health Agency as one visit only, unless services to each ~~Client~~Member are separate and

distinct. If two or more ~~Clients~~Members residing in the same household receive Medicaid CNA services, the services for each ~~Client~~ Member shall be documented and billed separately for each ~~Client~~Member.

~~4.No more than one Home Health Agency may be reimbursed for providing Home Health Services during a specific plan period to the same Client, unless the second agency is providing a Home Health Service that is not available from the first agency. The first agency shall take responsibility for the coordination of all Home Health Services. Home and Community-based Services, including personal care, are not Home Health Services.~~

4. In the event of limited resources for a Home Health Agency, two agencies may coordinate care and provide services to the same member as long as there is no duplication of services on the same date(s) of service and the Home Health Agencies comply with the following:

a. The Home Health Agencies shall document the need and reason for two Home Health Agencies to render services to a member.

b. The Home Health Agencies shall coordinate the member's Plan of Care and maintain the Plan of Care and documentation on all services rendered by each provider in the member's records.

c. Each Home Health Agency shall obtain prior authorization, identify to the URC the coordinated Plan of Care and revise the PAR as needed to ensure coverage.

5. Improper Billing Practices: Examples of improper billing include, but are not limited to:

a. Billing for visits without documentation to support the claims billed. Documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the ~~Client~~Member's home. Providers shall submit or produce requested documentation in accordance with rules at Section 8.076.2;

b. Billing for unnecessary visits, or visits that are unreasonable in number, frequency or duration;

c. Billing for CNA visits in which no skilled tasks were performed and documented;

d. Billing for skilled tasks that were not medically necessary;

e. Billing for Home Health Services provided at locations other than an eligible place of service, except EPSDT services provided with prior authorization; and

f. Billing of personal care or homemaker services as Home Health Services.

6. A Home Health Agency that is~~are~~ also certified as a personal care/homemaker provider shall ensure that neither duplicate billing nor unbundling of services occurs in billing for

Home Health Services and HCBS personal care services. Examples of duplicate billing and unbundling of services include:

a. One employee makes one visit, and the agency bills Medicaid for a CNA visit, and also bills all of the hours as HCBS personal care or homemaker.

b. One employee makes one visit, and the agency bills for one CNA visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 1 hour plus the number of hours billed for HCBS personal care and homemaker.

c. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of CNA and personal care or homemaker services.

7. The Department may take action against the offending Home Health Agency, including termination from participation in Colorado Medicaid in accordance with ~~10 C.C.R. 2505-10,~~ Section 8.076.

8.520.10 Compliance Monitoring Reviews

8.520.10.A. General Requirements

1. Compliance monitoring of Home Health Services may be conducted by state and federal agencies, their contractors and law enforcement agencies in accordance with ~~10 C.C.R. 2505-10,~~ Section 8.076.

2. Home Health Agencies shall submit or produce all requested documentation in accordance with ~~10 C.C.R. 2505-10,~~ Section 8.076.

3. ~~Physician~~ Physician or Allowed Practitioner -signed Plans of Care shall include nursing or therapy assessments, current clinical summaries and updates for the ~~Client~~Member. The Plan of Care shall be on the CMS-485 ~~form, or a form that is identical in content to the CMS-485.~~ Plan of Care, or a form that is of similar format to the CMS-485. All sections of the form shall be completed. All therapy services provided shall be included in the Plan of Care, which shall list the specific procedures and modalities to be used and the amount, duration and frequency.

4. Provider records shall document the nature and extent of the care actually provided.

5. Unannounced site visits may be conducted in accordance with Section 25.5-4-301(14)(b) C.R.S.

6. Home Health Services which are duplicative of any other services that the ~~Client~~Member has received funded by another source or that the ~~Client~~Member received funds to purchase shall not be reimbursed.

7. Services which total more than ~~twenty-four~~ 24 hours per day of care, regardless of funding source shall not be reimbursed.

8. Billing for visits or contiguous units which are longer than the length of time required to perform all the tasks prescribed on the care plan shall not be reimbursed.

9. Home Health Agencies shall not bill ~~Client~~Members or families of ~~Client~~Member for any services for which Medicaid reimbursement is recovered due to administrative, civil or

criminal actions by the state or federal government.

8.520.11 Denial, Termination, or Reduction in Services by the Home Health Agency

8.520.11.A. When services are denied, terminated, or reduced by action of the Home Health Agency, the Home Health Agency shall notify the ~~Client~~Member.

8.520.11.B. Termination of services to ~~Client~~Members still medically eligible for Coverage of Medicaid Home Health Services:

1. When a Home Health Agency decides to terminate services to a ~~client~~Member who needs and wants continued Home Health Services, and who remains eligible for coverage of services under the Medicaid Home Health rules, the Home Health Agency shall give the ~~client~~Member, or the ~~client~~Member's designated representative/legal guardian, written advance notice of at least 30 business days. The ~~Ordering Practitioner~~ Physician or Allowed Practitioner and the Department's Home Health Policy Specialist shall also be notified.

2. Written notice to the ~~Client~~Member, or ~~Client~~Member's designated representative/legal guardian shall be provided in person or by certified mail and shall be considered given when it is documented that the recipient has received the notice. The notice shall provide the reason for the change in services

3. The agency shall make a good faith effort to assist the ~~Client~~Member in securing the services of another agency.

4. If there is indication that ongoing services from another source cannot be arranged by the end of the advance notice period, the terminating agency shall ensure ~~Client~~Member safety by making referrals to appropriate case management agencies or County Departments of Social Services; and the attending ~~physician~~ Physician or Allowed Practitioner shall be informed.

5. Exceptions will be made to the requirement for 30 days advance notice when the provider has documented that there is immediate danger to the ~~Client~~Member, Home Health Agency, staff, or when the ~~Client~~Member has begun to receive Home Health Services through a Medicaid HMO.