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SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 19-07-19-A, Revision to the Medical Assistance Rule concerning Correction to Hospital Quality Incentive Payment (HQIP) Supplemental Payment Language, Section 8.3004.F
3. This action is an adoption of:	an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.3004.F, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	No
If yes, state effective date:	11/1/2019
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.3004.F.2 with the proposed text through the end of 8.3004.F.2. This rule is effective November 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Correction to Hospital Quality Incentive Payment (HQIP) Supplemental Payment Language, Section 8.3004.F
Rule Number: MSB 19-07-19-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

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 current language for the Hospital Quality Incentive Payment (HQIP) supplemental payment, reimbursed to a hospital through the Healthcare Affordability and Sustainability (HAS) program, incorrectly states psychiatric hospitals, long term care hospitals, and rehabilitation hospitals are excluded from the supplemental payment. Psychiatric hospitals are the only hospital type excluded from the supplemental payment.

   This rule change will list psychiatric hospitals as the only hospital type excluded from the HQIP supplemental payment to comply with both the approved State Plan and CHASE board recommendations. This rule change will have no impact on hospitals or the Department.

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:

3. Federal authority for the Rule, if any:

   42 C.F.R. § 433.68

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   Section 25.5-4-402.4(4)(g), C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Correction to Hospital Quality Incentive Payment (HQIP) Supplemental Payment Language, Section 8.3004.F
Rule Number: MSB 19-07-19-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

REGULATORY ANALYSIS

1. 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.

   No classes of persons will be affected by this rule change. Psychiatric hospitals are currently the only hospital type excluded from receiving the HQIP supplemental payment.

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

   There is no quantitative or qualitative impact of this rule change. The rule change only corrects rule language to match the calculation methodology currently experienced by the provider community.

3. 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.

   There is no cost to the Department or to any other agency with this rule change. The rule change only corrects rule language to match the calculation methodology currently experienced by the provider community.

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

   The cost of inaction would be rules not aligning with the current HQIP supplemental payment calculation methodology, State Plan, and previous CHASE board recommendations.

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

   This is the less costly/intrusive method for achieving the purpose of the proposed rule change.

DO NOT PUBLISH THIS PAGE

6. 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.

   There is no alternative method for achieving the purpose of the proposed rule change.

8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. General Hospitals and Critical Access Hospitals are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals~~, Long Term Care Hospitals, and Rehabilitation Hospitals are not qualified~~ are not qualified to receive this payment.

3. Measures. Quality incentive payment measures include nine measures. Qualified hospitals must report for the first and second measures. A hospital then reports for the remaining measures in which they are eligible

    a. The measures for the quality incentive payment are:

        i. Active participation in the Regional Care Collaborative Organizations (RCCO) or Regional Accountable Entities (RAE),

        ii. Culture of Safety/Patient Safety,

        iii. Discharge Planning (Advance Care Planning (ACP)/Transition Activities),

        iv. Rate of Cesarean Section,

        v. Breastfeeding Practices,

        vi. Tobacco and Substance Use Screening and Follow-Up,

        vii. Emergency Department Process,

        viii. Percentage of “9” or “10” on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and

        ix. 30-Day All-Cause Readmission.

4. The hospital shall certify that based on best information, knowledge, and belief, the data included in the data reporting template is accurate, complete, and truthful, is based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years. The certification shall be made by the hospital’s Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

5. Calculation methodology for payment.

    a. Determine total points earned.

        i. Total points earned are the sum of the points earned for the first and second measures and the next three sequential measures for which the hospital is eligible.

b. Normalize the total points for hospitals that are exempted from reporting requirements or have limited data available for certain measures.

c. Calculate adjusted Medicaid discharges.

i. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by a discharge adjustment factor.

ii. The discharge adjustment factor is calculated as gross Medicaid billed charges divided by gross inpatient Medicaid billed charges. The Discharge Adjustment Factor is limited to 5.

iii. For hospitals with fewer than 200 annual Medicaid discharges, the total number of discharges is multiplied by 125% to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare prospective payment system calculation.

d. Calculate total adjusted discharge points.

i. Adjusted discharge points are calculated as the total points earned for all measures multiplied by the adjusted Medicaid discharges.

e. Determine the dollars per discharge point.

i. Dollars per discharge point are tiered such that hospitals with higher quality points earned receive more dollars per discharge point than hospitals with lower quality points earned. There are five tiers delineating the dollar value of a discharge point with each tier assigned at certain quality point increments. For each tier increase, the dollars per discharge point increase by a multiplier.

ii. The multiplier for the five tiers of quality points are shown in the table below:

Tier	Hospital Quality Points Earned	Multiplier
1	1-19	$0.00
2	20-35	$3.13
3	36-50	$6.26
4	51-65	$9.39
5	66-80	$12.52

g. Calculate payment by hospital by multiplying the adjusted discharge points by the dollars per discharge point.

6. The dollars per discharge point for tier 2 will be set to an amount so that the total quality incentive payments made to all qualified hospitals will equal seven percent of the total reimbursement made to hospitals in the previous state fiscal year.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Emergency Medical Transportation, Section 8.018
Rule Number: MSB 19-04-19-B
Division / Contact / Phone: Health Programs Office / Whitney McOwen / 303-866-4441 / Ryan Dwyer / 303-866-3782

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 19-04-19-B, Revision to the Medical Assistance Benefits Rule Concerning Emergency Medical Transportation, Section 8.018
3. This action is an adoption of:	an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.018, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	No
If yes, state effective date:	N/A
Is rule to be made permanent? (If yes, please attach notice of hearing).	<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.018 with the proposed text beginning at 8.018.1 through the end of 8.018.A. This rule is effective November 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Emergency Medical Transportation, Section 8.018
Rule Number: MSB 19-04-19-B
Division / Contact / Phone: Health Programs Office / Whitney McOwen / 303-866-4441 / Ryan Dwyer / 303-866-3782

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 proposed revisions to this rule (1) incorporate existing Emergency Medical Transportation (EMT) provider eligibility and responsibility requirements, (2) change terminology of Critical Care Transportation to Specialty Care Transportation, and (3) add and align applicable definitions for clarification.

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:

3. Federal authority for the Rule, if any:

   42 CFR §§ 431.53, 440.170(a) (2019)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   25.5-5-202(2), C.R.S. (2018)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Emergency Medical Transportation, Section 8.018
Rule Number: MSB 19-04-19-B
Division / Contact / Phone: Health Programs Office / Whitney McOwen / 303-866-4441 / Ryan Dwyer / 303-866-3782

REGULATORY ANALYSIS

1. 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.

   Providers of EMT and Colorado Medicaid clients who utilize EMT will benefit from this rule revision, as it updates and adds clarity to the existing rule. There is no anticipated cost to members or providers associated with this rule revision.

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

   Many of the updates included in this rule revision incorporate existing practices and requirements. All of the updates being made to the rule are meant to add clarity and predictability for both providers and clients.

3. 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.

   There are no anticipated costs associated with these rule updates.

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

   The proposed rule has no anticipated costs and the anticipated benefit is added clarity for both providers and clients. The cost of inaction is that the rule will continue to be outdated.

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

   There are no less costly methods of achieving the purpose of the proposed rule.

6. 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.

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There are no alternative methods for achieving the purpose of the proposed rule, which is to bring the rule up to date.

8.018 EMERGENCY MEDICAL TRANSPORTATION

8.018.1. DEFINITIONS

8.018.1.A. ~~Advanced Life Support (ALS) means special services designed to provide definitive medical care en route from the client's pickup point to the medical facility or during inter-facility transfers and until responsibility for medical care is assumed by the staff of the receiving medical facility.~~

Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation. ~~helicopter or airplane designed and used to provide transportation for the ill and injured, and to provide personnel, facilities, and equipment to treat clients before and during transportation.~~

8.018.1.B. ~~Ambulance means any publicly or privately owned vehicle that is specially designed, constructed, modified or equipped to be used, maintained and operated on streets or highways to transport clients to a hospital or other treatment facility in cases of accident, trauma or severe illness.~~

~~Basic Life Support (BLS) means transportation by an ambulance vehicle and medically necessary supplies and services to include cardiopulmonary resuscitation as required to maintain life during transport from the client's pickup point to the provider's facility or during an inter-facility transfer, without cardiac/hemodynamic monitoring or other invasive techniques.~~Client means a person enrolled in the Medical Assistance Program.

8.018.1.C. Emergency Medical Services (EMS) Provider means an individual who has a current and valid emergency medical service provider certificate issued by the Department of Public Health and Environment (CDPHE) and includes Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), Emergency Medical Technician Intermediate (EMT-I), and Paramedic, in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two.~~S~~Critical Care Transport ~~means ambulance transportation during which a client receives specialized care for conditions that are life-threatening and who require comprehensive care and constant monitoring from a stabilizing hospital to a hospital with full capabilities for the client's case.~~

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

8.018.1.E. Emergency Medical Transportation means Ground ~~a~~Ambulance or Air Ambulance transportation during which ~~a C~~clients who are ill, injured, or otherwise mentally or physically incapacitated receive~~s~~ needed emergency medical services en route ~~to an appropriate medical facility~~.

8.018.1.F. Facility means a general hospital, hospital unit, psychiatric hospital, rehabilitation hospital, Acute Treatment Unit (ATU), or Crisis Stabilization Unit (CSU).

8.018.1.G. Fixed-Wing Air Ambulance means a fixed-wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.

8.018.1.H. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation~~designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat clients before and during transportation~~.

8.018.1.I. Interfacility Transportation means transportation of a Client from one Facility to another Facility.

8.018.1.J. Life-Sustaining Supplies means oxygen and oxygen supplies required for life-sustaining treatment during transport via ambulance.

8.018.1.K. Mileage means the number of miles the Client is transported in the ambulance.

8.018.1.L.

Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment that is covered by the Colorado Medical Assistance Program under S~~s~~ection 8.014. Non-emergency care may be scheduled or unscheduled. This may include urgent care transportation and hospital discharge transportation.

8.018.1.M. Paramedic means an individual who has a current and valid Paramedic certificate issued by CDPHE and who is authorized to provide acts of advanced emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two. For the purposes of these rules, Paramedic includes the historic Emergency Medical Service Provider level of EMT-Paramedic (EMT-P).

8.018.1.N. Paramedic with Critical Care Endorsement means an individual who has a current and valid Paramedic certificate issued by CDPHE and who has met the requirements in CDPHE rule to obtain a critical care endorsement from CDPHE and is authorized to provide acts in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight relating to critical care, as set forth in C.R.S. § 25-3.5-206.

8.018.1.O. Rotor~~-~~Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.018.1.P. Specialty Care Transport (SCT) means interfacility Ground Ambulance transportation of a critically injured or ill Client from a stabilizing hospital to a hospital with full capabilities to treat the Client's case. SCT is necessary when a Client's condition requires ongoing care during transport at a level of service beyond the scope of the EMT, that must be furnished by one or more health professionals in an appropriate specialty area including, but not limited to, nursing, emergency medicine, respiratory care, cardiovascular care, or a Paramedic with Critical Care Endorsement.~~Non-Emergency Medical Transportation (NEMT) means transportation to or from medical treatment that is not emergency in nature under Section 8.014.1~~

8.018.2. CLIENT ELIGIBILITY

8.018.2.A. Emergency Medical Transportation ~~ambulance service~~ is a benefit for all Colorado Medical Assistance Program C~~c~~lients who are ill, injured, or otherwise mentally or physically incapacitated and in need of ~~have a critical or unknown illness or injury that demands~~ immediate medical attention to prevent permanent injury or loss of life.

8.018.3. PROVIDER ELIGIBILITY

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

1. Meet all provider screening requirements in Ssection 8.125.

2. Comply with commercial liability insurance requirements.

3. Maintain and comply with the appropriate licensure:

a. Ground Ambulance license as required by CDPHE statute at C.R.S. § 25-3.5-301 and 6 CCR 1015-3, Chapter Four.

b. Air Ambulance license as required by CDPHE statute at C.R.S. § 25-3.5-307 and 6 CCR 1015-3, Chapter Five.

4. License, operate, and equip Ground and Air Ambulances in accordance with federal and state regulations.

~~Ambulances providing services to Medicaid clients must be licensed, operated, and equipped in accordance with federal and state regulations.~~

~~8.018.3.B. Ambulances must be operated by two Emergency Medical Technicians (EMTs). One technician must accompany the patient at all times.~~

8.018.4. COVERED SERVICES

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

8.018.4.~~A~~B. Ground Ambulance

1. The following ~~g~~Ground ~~a~~Ambulance Emergency Medical Transportation services are covered:

a. Transportation to the closest, most appropriate F~~f~~acility.

b. Basic life support (BLS) or advanced life support (ALS) required to maintain life during transport from the Client's pickup point to the treating Facility~~or advanced life support that is required during transport~~.

i. BLS includes:

1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;

2. Suctioning en route (not deep suctioning); and

3. Airway control/positioning.

ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference. This incorporation by reference excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for

public inspection during regular business hours, at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.

2. ALS Level 2 includes:

a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

b. The provision of at least one of the following ALS procedures:

i. Manual defibrillation/cardioversion.

ii. Endotracheal intubation.

iii. Central venous line.

iv. Cardiac pacing.

v. Chest decompression.

vi. Surgical airway.

vii. Intraosseous line.

c. ~~Critical~~ Specialty Care Transport~~ation.~~ when medically necessary to reach the closest, most appropriate Facility.~~facility to facility transport requiring medical care above that offered via non-emergency medical transportation.~~

d. Department-approved supplies used during Emergency Medical Transportation, including Life-Sustaining Supplies, are separately reimbursable when medically necessary.

8.018.4.C~~A~~. Air Ambulance

1. Air Ambulance Emergency Medical Transportation services are covered when:~~When the point of pick up is inaccessible by a land vehicle or remoteness or other obstacles prohibit transporting the client by land to the nearest appropriate medical facility, the following air ambulance services are covered:~~

a. They meet the criteria at Section 8.018.4.B.1.a.-b.; and~~Basic or advanced life support that is required during transport.~~

b. The point of pick up is inaccessible by a Ground Ambulance, or great distances or other obstacles prohibit transporting the Client by land to the nearest appropriate medical Facility.~~Critical Care Transport- when medically necessary to reach the closest, most appropriate facility.~~

8.018.4.D. Interfacility Transportation

1. Interfacility Transportation is covered when:

a. The Client requires a transfer from one Facility to another; and

b. The Client requires ALS or BLS services.

2. Interfacility Transportation can be provided via Ground or Air Ambulance.

8.018.5. NON-COVERED SERVICES AND GENERAL LIMITATIONS

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

1. Waiting time and~~,~~ cancellations.

2. ~~, or~~ Transportation of ~~unapproved~~ additional passengers.

3~~2~~. Response calls when determined ~~to emergency locations when~~ no transportation is needed or approved.

4~~3~~. Charges when the C~~c~~lient is not in the vehicle.

5~~4~~. Non-benefit services (e.g., first aid) provided at the scene when transportation is not necessary.

6~~5~~. Transportation which is covered by another entity.

7~~6~~. Transportation to local treatment programs not enrolled in Colorado Medical Assistance Program.

8~~7~~. Transportation of a C~~c~~lient who is deceased prior to transport~~has been pronounced deceased at the time that the ambulance arrives~~.

9~~8~~. Pick up or delivery of prescriptions ~~and/~~or supplies.

10~~9~~. Transportation arranged for a C~~c~~lient's convenience when there is no reasonable risk of permanent injury or loss of life.

11~~0~~. Transportation to non-emergency medical appointments or services. See Section 8.014 for NEMT services.

8.018.6. PRIOR AUTHORIZATION

8.018.6.A. Prior Authorization is not required for Emergency Medical Transportation.~~ground and air ambulance in emergency situations or for hospital to hospital transport including critical care transport.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Colorado National Provider Identifier Number, Section 8.126
Rule Number: MSB 19-07-10-B
Division / Contact / Phone: Health Information Office / Kaitlyn Skehan / (303) 866-2117

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 19-07-10-B, Revision to the Medical Assistance Rule concerning Colorado National Provider Identifier Number, Section 8.126
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.126, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert the proposed text beginning at 8.126 through the end of 8.126. This rule is effective November 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Colorado National Provider Identifier Number, Section 8.126
Rule Number: MSB 19-07-10-B
Division / Contact / Phone: Health Information Office / Kaitlyn Skehan / (303) 866-2117

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).

   HB 18-1282 requires newly enrolling and currently enrolled Organization Health Care Providers (not individuals) to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled in the Colorado interChange.

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:

   N/A

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   HB 18-1282

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Colorado National Provider Identifier Number, Section 8.126
Rule Number: MSB 19-07-10-B
Division / Contact / Phone: Health Information Office / Kaitlyn Skehan / (303) 866-2117

REGULATORY ANALYSIS

1. 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.

   Organization Health Care Providers (not individuals)

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

   Organization Health Care Providers will be impacted when they get/update their NPI numbers. The Department and other insurance entities will indirectly be impacted as the law will allow visibility into where services are being provided to members.

3. 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.

   Implementation efforts are estimated at around 5,280 hours.

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

   There are not cost benefits or benefits of inaction for this rule.

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

   This is the most cost effective and least intrusive method for achieving the purpose of this rule.

6. 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.

   There are not any alternative methods to this rule. It is a legislative requirement that a Health Care Provider include certain identifying information on all claims for reimbursement for health care services.

8.125 PROVIDER SCREENING

8.126 COLORADO NPI RULE

8.126.1 Definitions

A. Billing Provider Field means the data field on a Claim that reflects the Health Care Provider to which the payer issues payment.

B. Campus means the physical area immediately adjacent to the Hospital's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the Centers of Medicare and Medicaid Services to be part of the provider's campus.

C. Claim means a request for payment for the delivery of medical care, services, or goods authorized under the Medical Assistance Program, submitted to the Department through its fiscal agent by a Health Care Provider. Claim includes the transmission of encounter information for the purpose of reporting the delivery of medical care, services, or goods.

D. Health Care Provider means any person or organization that furnishes, bills for, or is paid for medical care, services, or goods to one or more Medical Assistance Program members.

1. A Health Care Provider includes an Organization Health Care Provider, Subpart of an Organization Health Care Provider, Off Campus Location, and a Site of an Organization Health Care Provider.

2. Unless specified otherwise in Subsection 8.126.1, a Health Care Provider may include a Health Care Provider located outside the state of Colorado (out-of-state provider) that is licensed and/or certified pursuant to their state laws.

E. Hospital means an Organization Health Care Provider that is enrolled in the Medical Assistance Program under the Provider Type of "Hospital - General" as defined in this Subsection 8.126.1.

F. Medical Assistance Program means the programs authorized under Articles 4, 5, 6, 8, and 10 of Title 25.5.

G. National Provider Identifier (NPI) means the standard, unique health identifier for Health Care Providers or Organization Health Care Providers that is used by the National Plan and Provider Enumeration System (NPPES) in accordance with 45 C.F.R. pt. 162.

H. Off-Campus Location means a facility that:

1. Has operations that are directly or indirectly owned or controlled by, in whole or in part, or affiliated with, a Hospital, regardless of whether the operations are under the same governing body as the Hospital;

2. Is not on the Hospital's Campus;

3. Provides services that are organizationally and functionally integrated with the Hospital;

4. Is an outpatient facility providing preventive, diagnostic, treatment, or emergency services; and

5. Is identified on the Hospital's State License Addendum issued by the Colorado Department of Public Health and Environment or, for Hospitals licensed outside of Colorado, documentation demonstrating direct or indirect ownership or control of the Off-Campus Location.

I. Organization Health Care Provider means a Health Care Provider that is not an individual.

J. Provider Type means a classification of Health Care Provider or Organization Health Care Provider to which the payer issues payment for services provided to individuals enrolled in the Medical Assistance Program, according to the Provider Type license, accreditation, certification, and/or service provided. The Provider Types recognized by the Department are as follows:

1. Administrative Services Organization (ASO) is an entity that has entered into a valid, active contract to provide ASO services with the Colorado Department of Health Care Policy and Financing.

2. Ambulatory Surgical Center (ASC) means a health care entity that is:

a. Licensed by the Colorado Department of Public Health and Environment as an Ambulatory Surgical Center; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as an Ambulatory Surgical Center.

3. Audiologist means an individual licensed as an audiologist by the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.

4. Behavioral Therapy Clinic means any group practice that has at least one affiliated Behavioral Therapy Individual. The affiliated Behavioral Therapy Individual must be enrolled in the Colorado Medical Assistance Program.

5. Behavioral Therapy Individual means an individual that:

a. Is nationally certified as a Board-Certified Behavioral Analyst (BCBA); or

b. Meets one of the following:

(1) Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology and is actively licensed by the State Board of Examiners; and has completed 400 hours of training; and/or has direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or

(2) Has a doctoral degree in one of the behavioral or health sciences; and has completed 800 hours of specific training; and/or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or

(3) Is nationally certified as a BCBA; or

(4) Has a master's degree or higher in behavioral or health sciences; and is a licensed teacher with an endorsement of school psychologist; or is a licensed teacher with an endorsement of special education or early childhood special education; or is credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist); and has completed 1,000 hours of direct supervised training or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

6. Birthing Center means a health care entity licensed as a Birth Center by the Colorado Department of Public Health and Environment. Out-of-state providers are not eligible for enrollment.

7. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers.

8. Certified Registered Nurse Anesthetist (CRNA) means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a CRNA.

9. Clinic – Dental means any group practice that has at least one affiliated, licensed dentist or dental hygienist.

a. The affiliated dentist or dental hygienist must be enrolled in the Colorado Medical Assistance Program; and

b. A dental practice or clinic must be owned by a licensed dentist except if the dental practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.); and

c. A dental hygiene practice or clinic must be owned by a licensed dentist or licensed dental hygienist except if the dental hygiene practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.)

10. Clinic – Practitioner means any group practice that has at least one affiliated, licensed physician, osteopath, or podiatrist. The affiliated practitioner must be enrolled in the Colorado Medical Assistance Program.

11. Community Clinic means a health care entity that is:

a. Licensed as a Community Clinic or Community Clinic and Emergency Center (CCEC) by the Colorado Department of Public Health and Environment;

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program; and

c. Owned by a Medicare participating hospital.

12. Community Mental Health Center (CMHC) means a health care entity that:

a. Is licensed as a Community Mental Health Center by the Colorado Department of Public Health and Environment;

b. Has program approval to operate as a CMHC from the Colorado Department of Human Services; and

c. If the CMHC delivers substance use disorder services, shall have Substance Use Disorder program approval from Colorado Department of Human Services.

13. Dental Hygienist means an individual who is licensed as a Dental Hygienist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.

14. Dentist means an individual who is licensed as a Dentist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.

15. Dialysis Treatment Clinic [Formerly Known as Dialysis Center] means a health care entity that is:

a. Licensed as a Dialysis Treatment Clinic by the Colorado Department of Public Health and Environment; and

b. Certified by Centers for Medicare and Medicaid Services to participate in the Medicare program as an End-Stage Renal Dialysis Facility (ESRD).

16. Federally Qualified Health Center (FQHC) means a health care entity that has been awarded a Section 330 Grant from the Health Resources and Services Administration. A health care entity that has been designated as a "look-alike" is also eligible to be enrolled as an FQHC.

17. Foreign Teaching Physician means an individual who is licensed as a distinguished foreign teaching physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

18. Home and Community Based Services (HCBS) means Health First Colorado (Colorado's Medicaid Program)'s community-based care alternatives to institutional, Long-Term care. Providers enrolling as an HCBS provider shall meet all applicable state and federal requirements to provide HCBS by waiver and specialty type.

19. Home Health Agency means a health care entity that:

a. Has a Class A Home Care Agency license from the Colorado Department of Public Health and Environment; and

b. Is certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as Home Health Agency.

20. Hospice means a health care entity that is:

a. Licensed as a Hospice by the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospice.

21. Hospital – General means a health care entity that is:

a. Licensed as a General Hospital by the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospital.

22. Hospital – Psychiatric [Formerly Known as Hospital - Mental] means a health care entity that is:

a. Licensed as a Psychiatric Hospital by the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Psychiatric Hospital.

23. Independent Laboratory means a laboratory that:

a. Has a current and valid Clinical Laboratory Improvement Amendments (CLIA) certification; and

b. Is certified through the Centers for Medicare and Medicaid Services as a laboratory.

24. Indian Health Service – Federally Qualified Health Center (FQHC) means a health care entity that:

a. Is treated by the Centers for Medicare and Medicaid Services as a comprehensive Federally funded health center; and

b. Includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

25. Indian Health Service – Pharmacy means a health care entity that has evidence of participation in the Indian Health Service.

26. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) [Formerly Known as Nursing Facility – ICF/IID] means a health care entity that is:

a. Licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities through the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as an ICF/IID.

27. Licensed Behavioral Health Clinician means an individual that is licensed by the Colorado Department of Regulatory Agencies as either:

a. A Licensed Clinical Social Worker;

b. A Licensed Professional Counselor;

c. A Licensed Marriage and Family Therapist; or

d. A Licensed Addiction Counselor.

28. Licensed Psychologist means an individual who is licensed as a psychologist by the State Board of Psychologist Examiners within the Colorado Department of Regulatory Agencies.

29. Managed Care Entity [Formerly Known as Health Maintenance Organization (HMO)] means an entity that has a valid and comprehensive or all-inclusive risk contract with the Colorado Department of Health Care Policy and Financing.

30. Non-Physician Practitioner Group means any group practice consisting of any of the following:

a. Licensed Nurse Practitioners;

b. Licensed Audiologists;

c. Licensed Occupational Therapists;

d. Licensed Behavioral Health Clinicians;

e. Licensed Psychologists; and/or

f. Licensed Speech Therapists.

31. Non-Physician Practitioner Individual means a registered nurse, which means an individual licensed as a Registered Nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies.

32. Nurse Midwife means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a Nurse Midwife.

33. Nurse Practitioner means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a Nurse Practitioner.

34. Nursing Facility means a health care entity that is:

a. Licensed as a Nursing Care Facility through the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as a Skilled Nursing Care Facility.

35. Occupational Therapist means an individual who is licensed as an Occupational Therapist by the Director of the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.

36. Optical Outlet means a health care supplier that is qualified to make and supply eyeglasses and contact lenses for the correction of vision. If, in the performance of its duties, the Optical Outlet requires laboratory services, the laboratory is required to have a current and valid CLIA certification.

37. Optometrist means an individual who is licensed as an Optometrist by the State Board of Optometry within the Colorado Department of Regulatory Agencies.

38. Osteopath means an individual who holds a degree of "doctor of osteopathy," and who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

39. Personal Care Agency means a health care entity that has a Class A or Class B Home Care Agency license from the Colorado Department of Public Health and Environment.

40. Pharmacist means an individual who is licensed as a Pharmacist by the State Board of Pharmacy within the Colorado Department of Regulatory Agencies.

41. Pharmacy means a pharmacy, pharmacy outlet, or prescription drug outlet registered by the Board of Pharmacy within the Colorado Department of Regulatory Agencies.

42. Physical Therapist means an individual who is licensed as a Physical Therapist by the Physical Therapy Board within the Colorado Department of Regulatory Agencies.

43. Physician means an individual who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

44. Physician Assistant means an individual who is licensed as a physician assistant by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

45. Podiatrist means an individual licensed as a podiatrist by the Colorado Podiatry Board within the Colorado Department of Regulatory Agencies.

46. Psychiatric Residential Treatment Facility (PRTF) means a health care entity that:

a. Is licensed by the Colorado Department of Human Services as a Residential Child Care Facility and a PRTF; and

b. Is certified as a qualified residential provider by the Department of Public Health and Environment; and

c. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children; and

d. Has provided an attestation to the Department that the PRTF is in compliance with the conditions of participation as required by Colorado Department of Human Services and the Centers for Medicare and Medicaid Services.

47. Qualified Medicare Beneficiary (QMB) Benefits Only means the provider type designation used for Chiropractors who participate under the QMB Program. Chiropractor means an individual licensed as a chiropractor by the Board of Chiropractic Examiners within the Colorado Department of Regulatory Agencies. QMB Benefits Only providers must also be certified as QMB Benefits Only providers through the Centers for Medicare and Medicaid Services.

48. Regional Accountable Entity (RAE) means an entity that has entered into a valid, existing contract with the Colorado Department of Health Care Policy and Financing to be a Regional Accountable Entity.

49. Rehabilitation Agency means a group practice that requires at least one affiliated and licensed professional enrolled in the Colorado Medical Assistance Program.

50. Residential Child Care Facility (RCCF) means a health care entity that is:

a. Designated by the Colorado Department of Human Services to provide Medicaid-reimbursable mental health services as an RCCF; and

b. Licensed by Colorado Department of Human Services as an RCCF.

51. Rural Health Clinic (RHC) means a clinic that is certified by the Centers for Medicare and Medicaid Services as a Rural Health Clinic.

52. School Health Services means a school district or Board of Cooperative Educational Services that has a valid, active contract with the Colorado Department of Health Care Policy and Financing to participate in the Colorado School Health Services Program.

a. The Site at which an Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program enrolled under the Provider Type of School Health Services is a school district.

53. Speech Therapist is an individual certified as a Speech Language Pathologist by the Director of the Divisions of Professions and Occupations within the Colorado Department of Regulatory Agencies.

54. Substance Use Disorder (SUD) – Clinic means a health care entity that:

a. Is licensed as a SUD Provider by the Colorado Department of Human Services;

b. Has program approval to operate as a SUD – Clinic from Colorado Department of Human Services; and

c. Has at least one affiliated advanced practice nurse, physician/psychiatrist, physician assistant, or behavioral health clinician who is certified in addiction medicine.

55. Supply means a Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) provider that meets one or both of the following definitions:

a. Complex Rehabilitation Technology (CRT) Supplier means a health care supplier that meets all the requirements of Section 8.590.5.D, and that:

(1) Has a Sales Tax Certificate or Tax-Exempt Certificate;

(2) Has CRT Professional Certification; and

(3) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS and CRT.

b. Durable Medical Equipment (DME) means a health care supplier that meets the requirements of Sections 8.590.5.A and B, and that:

(1) Has a Sales Tax Certificate or Tax-Exempt Certificate; and

(2) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS.

56. Transportation means a provider that meets one or both of the following definitions:

a. Emergency Medical Transportation (EMT) [Formerly Known as Emergency Medical Transportation and Air Ambulance] means providers that:

(1) Meet all provider screening requirements in Section 8.125.

(2) Comply with commercial liability insurance requirements.

(3) Maintain the appropriate licensure for:

(a) Ground ambulance license as required by Colorado Department of Public Health and Environment; and

(b) Air ambulance license as required by Colorado Department of Public Health and Environment.

(4) License, operate, and equip ground and air ambulances in accordance with federal and state regulations.

b. Non-Emergent Medical Transportation (NEMT) means a provider that:

(1) Has a Public Utilities Commission (PUC) common carrier certificate as a taxicab; or

(2) Has a PUC Medicaid Client Transport (MCT) Permit as required by the PUC; or

(3) Has a ground ambulance license as required by Department of Public Health and Environment; or

(4) Has an Air Ambulance license as required by Colorado Department of Public Health and Environment; or

(5) Is exempt from licensure requirements in accordance with the PUC.

57. X-Ray Facility means an imaging center that:

a. Has an X-Ray Facility and Machine Registration Report certified by the Colorado Department of Public Health and Environment; and

b. Is certified by the Centers for Medicare and Medicaid Services to participate in Medicare as an X-Ray facility.

K. Service Facility Location Field means the physical location specifically where services were rendered as identified on the Claim.

L. Site means the physical location by street address, including suite number, where goods and/or services are provided. The term Site when involving a Health Care Provider that voluntarily contracts with a RAE as a Primary Care Medical Provider (PCMP) to participate in the Department's Accountable Care Collaborative (ACC) as a medical home, also includes the following requirements:

1. PCMP services must be identifiable from other goods and/or services, including services provided by specialists provided by the Health Care Provider in the same physical location through a separate and unique NPI.

2. PCMP services provided at a Campus or Off-Campus Location must be identifiable from other goods and/or services, including services provided by specialists, provided by the Health Care Provider on the same Campus or Off-Campus Location through a separate and unique NPI.

M. Subpart means a component or separate physical location of an Organization Health Care Provider that may be separately licensed or certified. This definition is intended to be consistent with the use of the term "Subpart" as defined in 45 C.F.R. pt. 162.

N. The definitions in Subsection 8.126.1 apply only to Section 8.126.

8.126.2 Enrollment of Health Care Providers

A. Health Care Providers must enroll in the Medical Assistance Program through the Department's Fiscal Agent, if they:

1. deliver medical care, services, or goods authorized under the Medical Assistance Program; and

2. are required to submit a Claim.

8.126.3 Health Care Provider Requirements to Obtain and Use an NPI

A. A Health Care Provider that is required or eligible to obtain an NPI pursuant to 45 C.F.R. § 162.410 must:

1. Enroll with a unique NPI that identifies the Health Care Provider that delivers medical care, services, or goods authorized under the Medical Assistance Program; and

2. Utilize the Health Care Provider's unique NPI for all Claims.

a. A Health Care Provider that is not enrolled as of January 1, 2020, must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2020.

b. All Off Campus Locations must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2020.

c. All Health Care Providers must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2021.

d. On every Claim, including Coordination of Benefits Agreement (COBA) automatic crossover Claims, the Organization Health Care Provider shall use the Service Facility Location Field to represent the most specific Site with an NPI where the services are rendered unless the Billing Provider Field represents the most specific Site with an NPI where the services are rendered.

8.126.4 Organization Health Care Provider Requirements to Obtain and Use an NPI

A. Each Organization Health Care Provider and each Subpart of an Organization Health Care Provider that is required or eligible to obtain an NPI pursuant to 45 C.F.R. § 162.410 must enroll using a unique NPI.

1. Each Organization Health Care Provider must enroll using its unique NPI for each Site at which the Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program.

a. A Hospital must enroll in the Medical Assistance Program with a unique NPI for:

(1) Its Campus; and

(2) Each Off-Campus Location.

2. Each Organization Health Care Provider must enroll in the Medical Assistance Program using a unique NPI for each Provider Type at each Site from which the Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program.

a. A Hospital must enroll with a unique NPI for each Provider Type at each Site at its Campus and at each Off-Campus Location at which it delivers medical care, services, or goods authorized under the Medical Assistance Program.

3. An Organization Health Care Provider that is a School Health Services provider type must enroll once per School District and not each individual Site.

8.126.5 Health Care Provider Requirements Not Eligible to Receive an NPI

A. A Health Care Provider that is not eligible pursuant to 45 C.F.R. § 162.410 to receive an NPI shall:

1. Enroll without submitting an NPI. The Health Care Provider must obtain a unique identification number assigned by the Department through its Fiscal Agent, that identifies both the unique Provider Type at each Site at which the Health Care Provider delivers medical care, services or goods authorized under the Medical Assistance Program; and

2. Use the unique identification number assigned by the Department through its Fiscal Agent on every Claim.

a. A Health Care Provider that is not eligible to obtain an NPI that is not enrolled as of January 1, 2020, must submit every Claim using the unique identification number used for enrollment that identifies both the Provider Type and Site, effective January 1, 2020.

b. All Health Care Providers that are not eligible to obtain an NPI must submit every Claim using the unique identification number used for enrollment that identifies both the Provider Type and Site, effective January 1, 2021.

8.126.6 New Providers as of January 1, 2020

A. A Health Care Provider that is not enrolled as of January 1, 2020, shall not apply to be enrolled to deliver medical care, services, or goods authorized under the Medical Assistance Program unless the Health Care Provider complies with Section 8.126.

8.126.7 Existing Providers as of January 1, 2021

A. A Health Care Provider that is enrolled as of January 1, 2021, shall not apply to have their enrollment revalidated to deliver medical care, services, or goods authorized under the Medical Assistance Program, as required under 42 C.F.R. § 455.414, unless the Health Care Provider complies with Section 8.126.

8.130 PROVIDER PARTICIPATION

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Non-Emergent Medical Transportation, Section 8.014
Rule Number: MSB 19-04-19-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927 / Ryan Dwyer / 303-866-3782

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 19-04-19-A, Revision to the Medical Assistance Benefits Rule Concerning Non-Emergent Medical Transportation, Section 8.014
3. This action is an adoption of:	an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.014, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	No
If yes, state effective date:	N/A
Is rule to be made permanent? (If yes, please attach notice of hearing).	<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.014 with the proposed text beginning at 8.014.1 through the end of 8.014.8. This rule is effective November 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Non-Emergent Medical Transportation, Section 8.014
Rule Number: MSB 19-04-19-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927 / Ryan Dwyer / 303-866-3782

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 proposed revisions to this rule will (1) incorporate existing Non-Emergent Medical Transportation (NEMT) policies; (2) include member responsibilities, exceptions to the requirement that members are reimbursed the shortest distance for personal vehicle mileage reimbursement, and the timeline for members to submit documentation for reimbursement; and (3) add provider eligibility and responsibilities and provider trip report documentation requirements; and (4) add and align applicable definitions.

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:

3. Federal authority for the Rule, if any:

   42 USC 1396a(a)(70) (2019) / 42 CFR 440.170(a) (2019)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   25.5-5-202(2), 25.5-5-324, C.R.S. (2018)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Non-Emergent Medical Transportation, Section 8.014
Rule Number: MSB 19-04-19-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927 / Ryan Dwyer / 303-866-3782

REGULATORY ANALYSIS

1. 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.

   Providers of NEMT and Colorado Medicaid clients who utilize NEMT will benefit from this rule revision, as it updates and adds clarity to the existing rule. There is no anticipated cost to members or providers associated with this rule revision.

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

   Many of the updates included in this rule revision incorporate existing practices and requirements. All of the updates being made to the rule are meant to add clarity and predictability for both providers and clients.

3. 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.

   There are no anticipated costs associated with these rule updates.

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

   The proposed rule has no anticipated costs and the anticipated benefit is added clarity for both providers and clients. The cost of inaction is that the rule will continue to be outdated.

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

   There are no less costly methods of achieving the purpose of the proposed rule.

6. 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.

DO NOT PUBLISH THIS PAGE

There are no alternative methods for achieving the purpose of the proposed rule, which is to bring the rule up to date.

8.014 NON-EMERGENT MEDICAL TRANSPORTATION

8.014.1. DEFINITIONS

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

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

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

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

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

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

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

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

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

8.014.1.J. Fixed-Wing Air Ambulance means a fixed wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.

8.014.1.K. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.L. Medicaid Client Transport (MCT) Permit means a permit issued by the Colorado Department of Regulatory Agencies Public Utilities Commission (PUC) in accordance with the PUC statute at ~~C.R.S.~~ Section§ 40-10.1-302, ~~.~~C.R.S.

8.014.1.M. Mode means the method of transportation.

8.014.1.N. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment that is covered by the Colorado Medical Assistance Program. Non-emergency care may be scheduled or unscheduled. This may include Urgent Care transportation and hospital discharge transportation.

8.014.1.O. Program of All Inclusive Care for the Elderly (PACE) is a capitated rate benefit which provides all-inclusive long-term care to certain individuals as defined in Ssection 8.497.

8.014.1.P. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.014.1.Q. State Designated Entity (SDE) means the organization responsible for administering NEMT. For the purposes of this rule, the responsible SDE is determined by the client's county of residence.

8.014.1.R. Stretcher Van means a vehicle that can legally transport a client in a prone or supine position when the client does not require medical attention en route. This may be by stretcher, board, gurney, or another appropriate device.

8.014.1.S. Taxicab means a motor vehicle operating in Taxicab Service, as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference. ~~The incorporation by reference of materials throughout section 8.014 excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours, at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.~~

8.014.1.T. Taxicab Service has the same meaning ~~means passenger transportation~~ as defined in 4 CCR 723-6, § 6~~2~~001(~~r~~yyy) (2019), which is hereby incorporated by reference.

8.014.1.U. Trip means one-way transportation from the point of origin to the point of destination.

8.014.1.V. Urgent Care means an ~~unplanned~~ appointment for a covered medical service with verification from an attending physician or facility that the client must be seen or picked up from a discharged appointment within 48 hours.

8.014.1.W. Wheelchair Vehicle means a motor vehicle designed and used for the non-emergent transportation of individuals with disabilities who use a wheelchair. These ~~as defined in C.R.S. § 42-7-510(2)(b). These~~ vehicles include vans modified for wheelchair Access or wheelchair accessible minivans.

8.014.2. CLIENT ELIGIBILITY AND RESPONSIBILITIES

8.014.2.A. All Colorado Medical Assistance Program clients are eligible for NEMT services unless the client falls within the following eligibility groups on the date of the Trip:

1. Qualified Medicaid Beneficiary (QMB) Only

2. Special Low Income Medicare Beneficiary (SLMB) Only

3. Medicare Qualifying Individual-1 (QI-1) Only

4. Old Age Pension- State Only (OAP-state only)

8.014.2.B. Child Health Plan Plus clients are not eligible for NEMT.

8.014.2.C. PACE clients receive transportation provided by their PACE organization and are not eligible for NEMT.

8.014.2.D. NEMT services may be denied if clients do not observe the following responsibilities:

1. Comply with applicable state, local, and federal laws during transport.

2. Comply with the rules, procedures and policies of the SDE.

3. Obtain authorization from their SDE.

4. Clients must not engage in violent~~, disruptive,~~ or illegal conduct while utilizing NEMT services.

5. Clients must not pose a direct threat to the health or safety of themselves or others, including drivers.

6. Clients must cancel their previously scheduled NEMT Trip if the ride is no longer needed, except in emergency situations or when the client is otherwise unable to cancel.

~~8.014.2.E. Pursuant to sSection 8.065, a client may be responsible to repay any services used that are not NEMT covered services. No recovery shall be made where the overpayment occurred through no fault of the client.~~

8.014.3. PROVIDER ELIGIBILITY AND RESPONSIBILITIES

8.014.3.A. Providers must enroll with the Colorado Medical Assistance Program as an NEMT provider.

8.014.3.B. Enrolled NEMT providers must:

1. Meet all provider screening requirements in S~~s~~ection 8.125;

2. Comply with commercial liability insurance requirements and, if applicable, PUC financial responsibility requirements established in the PUC statute at C.R.S. § 40-10.1-107;

3. Refrain from attempting to solicit clients known to have already established NEMT service with another provider;

4. Maintain and comply with the following appropriate licensure, or exemption from licensure, requirements:

   a. PUC common carrier certificate as a Taxicab;

   b. PUC MCT Permit as required by the PUC statute at C.R.S. § 40-10.1-302;

   c. Ground Ambulance license as required by Department of Public Health and Environment (CDPHE) rule at 6 CCR 1015-3, Chapter Four;

   d. Air Ambulance license as required by CDPHE rule at 6 CCR 1015-3, Chapter Five; or

   e. Exemption from licensure requirements in accordance with PUC statute at C.R.S. § 40-10.1-105.

5. Only provide NEMT services appropriate to their current licensure(s) and within the geographic limitations applicable to the licensure; and

6. Ensure that all vehicles and auxiliary equipment used to transport clients meet federal, state, and local safety inspection and maintenance requirements.

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

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

1. The pick-up address;

2. The destination address, which must be a covered place of service under Section 8.014.4;

3. Date and time of the Trip;

4. Client's name or identifier;

5. Confirmation that the driver verified the client's identity;

6. Confirmation by the client, Escort, or medical facility that the Trip occurred;

7. The actual pick-up and drop off time;

8. The driver's name; and

9. Identification of the vehicle in which the Trip was provided.

8.014.3.D. Multiple Loading

1. Except as otherwise specified at Section 8.014.3.D.2., NEMT providers may transport more than one client at the same time if:

   a. Standard safety guidelines are followed;

   b. Each client agrees to be transported with other clients;

   c. No client is in the vehicle for more than thirty minutes longer than if the client were transported alone; and

   d. Children traveling without an Escort are transported only with persons known by such Children including, but not limited to, other Children attending the same service, family members, or friends, at all times.

2. Taxicabs must comply with applicable PUC rules regarding multiple passengers at 4 CCR 723-6, § 6252~~3~~ (2019), which is hereby incorporated by reference.

8.014.3.E. The S~~s~~ection 8.014.3 requirements do not apply to client reimbursement or bus or rail systems.

8.014.4. COVERED PLACES OF SERVICE

8.014.4.A. NEMT must be to service location(s) enrolled with the Colorado Medical Assistance Program to provide the medical services the client is receiving, regardless of whether the medical services will be paid for by the Colorado Medical Assistance Program or another entity.

8.014.4.B. NEMT must be provided to the closest provider available qualified to provide the service the client is traveling to receive. The closest provider is defined as a provider within a 25-mile radius of the client's residence, or the nearest provider if one is not practicing within a 25-mile radius of the client's residence. Exceptions may be made by the SDE in the following circumstances:

1. If the closest provider is not willing to accept the client, the client may use NEMT to access the next closest qualified provider.

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

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

8.014.5. COVERED SERVICES

8.014.5.A. Transportation Modes

1. Covered Modes of transportation include:

   a. Bus and public rail systems

      i. Transit passes may be issued by the SDE when the cumulative cost of bus tickets exceeds the cost of a pass.

   b. Personal vehicle mileage reimbursement

   c. Ambulatory Vehicles

   d. Wheelchair Vehicles

   e. Taxicab Service

   f. Stretcher Van

   g. Ground Ambulance

   h. Air Ambulance

   i. Commercial plane

   j. Train

8.014.5.B. NEMT Services

1. NEMT is a covered service when:

   a. The client does not have Access to other means of transportation, including free tTransportation;

   b. Transportation is required to obtain a non-emergency service(s) that is medically necessary, as defined in Ssection 8.076.1.8.; and

   c. The client is receiving a service covered by the Colorado Medical Assistance Program.

2. NEMT services may be covered for clients even if the medical procedure is paid for by an entity other than the Colorado Medical Assistance Program.

3. Non-emergent ambulance service (Ground and Air Ambulance), from the client's pickup point to the treating facility, is covered when:

   a. Transportation by any other means would endanger the client's life; or

   b. The client requires basic life support (BLS) or advanced life support (ALS) to maintain life and to be transported safely.

      i. BLS includes:

         1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;

         2. Suctioning en route (not deep suctioning); and

         3. Airway control/positioning.

      ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference.

         1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.

         2. ALS Level 2 includes:

            a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

            b. The provision of at least one of the following ALS procedures:

               i. Manual defibrillation/cardioversion.

               ii. Endotracheal intubation.

               iii. Central venous line.

               iv. Cardiac pacing.

               v. Chest decompression.

               vi. Surgical airway.

               vii. Intraosseous line.

4. NEMT may be provided to an Urgent Care appointment under the following circumstances:

   a. A provider is available;

   b. The appointment is for a covered medical service with verification from an attending physician that the client must be seen within 48 hours; and

c. The client is transported to an Urgent Care facility, which may include a trauma center if it is the nearest and most appropriate facility.

8.014.5.C. Personal Vehicle Mileage Reimbursement

1. Personal vehicle mileage reimbursement is covered for a privately owned, non-commercial vehicle when used to provide NEMT services in accordance with ~~s~~Section 8.014.5.B and owned by:

   a. A client, a client's relative, or an acquaintance; or

   b. A volunteer or organization with no vested interest in the client.

2. Personal vehicle mileage reimbursement will only be made for the shortest Trip length in miles as determined by an internet-based map, Trip planner, or other Global Positioning System (GPS).

   a. Exceptions can be made by the SDE if the shortest distance is impassable due to:

      i. Severe weather;

      ii. Road closure; or

      iii. Other unforeseen circumstances outside of the client's control that severely limit using the shortest route.

   b. If an exception is made under ~~s~~Section 8.014.5.C.2.a., the SDE must document the reason and pay mileage for the actual route traveled.

3. To be reimbursed for personal vehicle mileage, the client must provide the following information to the SDE within forty-five (45) calendar days of the final leg of the Trip:

   a. Name and address of vehicle owner and driver (if different from owner);

   b. Name of the insurance company and policy number for the vehicle; and

   c. Driver's license number and expiration date.

8.014.5.D. Ancillary Services

1. Escort

   a. The Colorado Medical Assistance Program may cover the cost of transporting one Escort when the client is:

      i. A Child.

         1. An Escort is required to accompany a client if the client is under thirteen (13) years old, unless the Child:

            a. Is traveling to a Day Treatment program (Children are not eligible for NEMT travel to and from school-funded day treatment programs);

b. The parent or guardian signs a written release;

c. An adult will be present to receive the Child at the destination and return location; and

d. The Day Treatment program and the parents approve of the NEMT provider used.

2. Clients who are at least thirteen (13) years old, but younger than eighteen (18) years old, may travel without an Escort if:

a. The parent or guardian signs a written release; ~~with a written release from their parent or guardian.~~and

~~a.~~ An adult will be present to receive the Child at the destination and return location.~~If a Child is traveling without an Escort, an adult must be present to receive the minor at both the destination and the return location.~~

ii. An At-Risk Adult unable to make personal or medical determinations, or to provide necessary self-care, as certified in writing by the client's attending Colorado Medical Assistance Program enrolled NEMT provider.

b. The Escort must be physically and cognitively capable of providing the needed services for the client.

i. If a client's primary caregiver has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay, a second Escort may be covered under S~~s~~ection 8.014.5.D.1.c.ii.

c. The Colorado Medical Assistance Program may cover the cost of transporting a second Escort for the client, if prior authorized under S~~s~~ection 8.014.7. A second Escort will only be approved if:

i. The client has a behavioral or medical condition which may cause the client to be a threat to self or to others if only one Escort is provided; or

ii. The client's primary caregiver Escort has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay.

~~d. Clients who are at least thirteen (13) years old, but younger than eighteen (18) years old, may travel without an Escort with a written release from their parent or guardian. If a Child is traveling without an Escort, an adult must be present to receive the minor at both the destination and the return location.~~

2. Meals and Lodging

a. Meals and lodging for in-state treatment may be reimbursed when:

i. Travel cannot be completed in one calendar day; or

ii. The client requires ongoing, continuous treatment and:

1. The cost of meals and lodging is less than or equal to the cost of traveling to and from the treatment facility and the client's residence; or

2. The client's treating medical professional determines that traveling to and from the client's residence would put the client's health at risk.

b. Meals and lodging may be covered for the Escort(s) when the client is a Child or an At-Risk Adult who requires the Escort's continued stay under ~~s~~Section 8.014.5.D.1.

c. Reimbursement will only be made for meals and lodging for which clients and Escorts are actually charged, up to the per diem rate established by the Colorado Medical Assistance Program. ~~If a client is not normally billed for meals or lodging, reimbursement will not be made.~~

d. Meals and lodging will not be paid or reimbursed when those services are included as part of an inpatient stay.

8.014.6. NON-COVERED NEMT SERVICES AND GENERAL LIMITATIONS

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

1. Services provided only as a convenience to the client.

2. Charges incurred while client is not in the vehicle, except for lodging and meals in accordance with S~~s~~ection 8.014.5.D.2.

3. Transportation to or from non-covered medical services, including services that do not qualify due to coverage limitations and services provided at locations not included in S~~s~~ection 8.014.4.

4. Waiting time.

5. Cancellations.

6. Transportation which is covered by another entity.

7. Metered taxi services.

8. Charges for additional passengers, including siblings or Children, not receiving a medical service, except when acting as an Escort under S~~s~~ection 8.014.5.D.1.

9. Transportation for nursing facility or group home residents to medical or rehabilitative services required in the facility's program, unless the facility does not have an available vehicle.

10. Transportation to emergency departments to receive emergency services. See S~~s~~ection 8.018 for Emergency Medical Transportation services.

11. Providing Escorts or the Escort's wages.

12. Trips to receive Home and Community Based Services

a. Non-medical transportation should be utilized if other transportation options are not available to the client.

8.014.6.B. General Limitations

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

8.014.7. AUTHORIZATION

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

1. Authorization requests submitted more than three months after an NEMT service is rendered will be denied.

2. NEMT services may be denied if proper documentation is not provided to the SDE.

8.014.7.B. If a client requests transportation via Wheelchair Vehicle, Stretcher Van, or ambulance, the SDE must verify the service is medically necessary with the client's medical provider

1. Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

8.014.7.C. Out-of-State NEMT

1. NEMT to receive out of state treatment is permissible only if treatment is not available in the state of Colorado.

2. The following border towns are not considered out of state for the purposes of NEMT prior authorization:

a. Arizona: Flagstaff and Teec Nos Pos.

b. Kansas: Elkhart, Goodland, Johnson, Sharon Springs, St. Francis, Syracuse, Tribune.

c. Nebraska: Benkelman, Cambridge, Chappell, Grant, Imperial, Kimball, Ogallala, and Sidney.

d. New Mexico: Aztec, Chama, Farmington, Raton, and Shiprock.

e. Oklahoma: Boise City.

f. Utah: Monticello and Vernal.

g. Wyoming: Cheyenne and Laramie.

8.014.7.D. Prior Authorization

1. The following services require prior authorization by ~~Health First Colorado~~Colorado Medical Assistance Program:

a. Out-of-state travel, except to the border towns identified at section 8.014.7.C.2.

b. Air travel, both commercial air and Air Ambulance.

c. Train travel via commercial railway.

d. Second Escort.

2. Prior authorization requests require the following information:

a. NEMT prior authorization request form completed by SDE and member's physician and submitted to Colorado Medical Assistance Program according to form instructions.

i. The Colorado Medical Assistance Program will return requests completed by non-physicians and incomplete requests to the SDE.

ii. The Colorado Medical Assistance Program's determination will be communicated to the SDE. If additional information is requested, the SDE must obtain the information and submit to the Colorado Medical Assistance Program. If the request is denied, the SDE must send the client a denial notice.~~The Department shall assure transportation to and from medically necessary services covered by the Colorado Medical Assistance Program for clients who have no other means of transportation. Payment will be made for the least expensive means suitable to the client's condition. The distance to be traveled, transportation and treatment facilities available and the physical condition and welfare of the client shall all determine the type of transportation service authorized.~~

8.014.8. INCORPORATIONS BY REFERENCE

The incorporation by reference of materials throughout section 8.014 excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours, at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960
Rule Number: MSB 19-07-10-A
Division / Contact / Phone: Special Financing / Chandra Vital / 303-866-5506

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 19-07-10-A, Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960
3. This action is an adoption of:	an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.960, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	8/9/19
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.960 with the proposed text beginning at 8.960.1 through the end of 8.960.3.E. Replace the current text at 8.960 Appendix A with the proposed text beginning at 8.960 Appendix A through the end of Appendix A. This rule is effective November 30, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960
Rule Number: MSB 19-07-10-A
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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 purpose of this rule is to comply with HB 19-1326 that states a maximum amount per procedure must not be less than the current reimbursement schedule of Medicaid. There are 36 procedure codes in Appendix A that are required to change.

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:

3. Federal authority for the Rule, if any:

   42 C.F.R. 162.1002(a)(4)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   Sections 25.5-3-404(4), C.R.S. (2019)

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REGULATORY ANALYSIS

1. 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.

   This rule is in accordance with HB 19-1326 which stipulates that any procedures listed in Appendix A are not less than Medicaid fee-for-service rates. The Grantees of the program will receive more payment for the affected procedure codes. The eligible seniors of the program will not be affected by these changes.

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

   The incorporation of the changes made by HB 19-1326 will have the same max-copayment as others in the appropriate sections listed in Appendix A. Therefore, there is no change in cost or economic impact on eligible seniors.

3. 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 Colorado Dental Health Care Program for Low-Income Seniors has a fixed appropriation and the increase of the program payments of these services will not increase the Department's administrative costs for the program.

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

   The incorporation of these procedure code increases keeps the Department inline with the passing of HB 19-1326.

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

   This rule change is necessary to incorporate these changes per HB 19-1326.

DO NOT PUBLISH THIS PAGE

6. 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.

   This rule change is necessary to incorporate these procedure code changes to adhere to HB 19-1326.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.1 Definitions

Arrange For or Arranging For means demonstrating established relations with Qualified Providers for any of the Covered Dental Care Services not directly provided by the applicant.

Covered Dental Care Services include Diagnostic Imaging, Emergency Services, Endodontic Services, Evaluation, Oral and Maxillofacial Surgery, Palliative Treatment, Periodontal Treatment, Preventive Services, Prophylaxis, Removable Prosthesis, and Restorative Services as listed by alphanumeric procedure code in Appendix A.

C.R.S. means the Colorado Revised Statutes.

Dental Health Professional Shortage Area or Dental HPSA means a geographic area, population group, or facility so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Dental Prosthesis means any device or appliance replacing one or more missing teeth and associated structures if required.

Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (20194).

Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation.

Economically Disadvantaged means a person whose Income is at or below 250% of the most recently published federal poverty level for a household of that size.

Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is able to demonstrate lawful presence in the country, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective August 30, 2016), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 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: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

Emergency Services means the need for immediate intervention by a Qualified Provider to stabilize an oral cavity condition.

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

Evaluation means an assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions.

Federally Qualified Health Center means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations as defined in 42 U.S.C. section 1395x (aa)(4).

Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, or interest that are received by an individual or family. Income may be self-declared. Resources are not included in Income.

Max Allowable Fee means the total reimbursement listed by procedure for Covered Dental Care Services under the Colorado Dental Health Care Program for Low-Income Seniors in Appendix A. The Max Allowable Fee is the sum of the Program Payment and the Max Client Co-Pay.

Max Client Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure in Appendix A for Covered Dental Services under the Colorado Dental Health Care Program for Low-Income Seniors.

Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (20194).

Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (20194).

Oral and Maxillofacial Surgery means the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Palliative Treatment for dental pain means emergency treatment to relieve the client of pain; it is not a mechanism for addressing chronic pain.

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

Preventive Services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.

Program Payment means the maximum amount by procedure listed in Appendix A for Covered Dental Care Services for which a Qualified Grantee may invoice the Department under the Colorado Dental Health Care Program for Low-Income Seniors. Program Payment must not be less than the reimbursement schedule for fee-for-service dental fees under the medical assistance program established in Articles 4, 5, and 6 of 10 CCR 2505-10.

Prophylaxis means the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.

Qualified Grantee means an entity that can demonstrate that it can provide or Arrange For the provision of Covered Dental Care Services and may include but is not limited to:

1. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (20194);

2. A community-based organization or foundation;

3. A Federally Qualified Health Center, safety-net clinic, or health district;

4. A local public health agency; or

5. A private dental practice.

Qualified Provider means a licensed dentist or dental hygienist in good standing in Colorado or a person who employs a licensed dentist or dental hygienist in good standing in Colorado and who is willing to accept reimbursement for Covered Dental Services. A Qualified Provider may also be a Qualified Grantee if the person meets the qualifications of a Qualified Grantee.

Removable Prosthesis means complete or partial Dental Prosthesis, which after an initial fitting by a dentist, can be removed and reinserted by the eligible senior.

Restorative Services means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic needs of the client.

Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (20194).

8.960.2 Legal Basis

The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S. (20194).

8.960.3 Request of Grant Proposals and Grant Award Procedures

8.960.3.A Request for Grant Proposals

Grant awards shall be made through an application process. The request for grant proposals form shall be issued by the Department and posted for public access on the Department's website at https://www.colorado.gov/hcpf/research-data-and-grants at least 30 days prior to the due date.

8.960.3.B Evaluation of Grant Proposals

Proposals submitted for the Colorado Dental Health Care Program for Low-Income Seniors will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.

1. The review panel will be comprised of individuals who are deemed qualified by reason of training and/or experience and who have no personal or financial interest in the selection of any particular applicant.

2. The sole objective of the review panel is to recommend to the Department's executive director those proposals which most accurately and effectively meet the goals of the program within the available funding.

3. Preference will be given to grant proposals that clearly demonstrate the applicant's ability to:

    a. Outreach to and identify Eligible Seniors;

    b. Collaborate with community-based organizations; and

    c. Serve a greater number of Eligible Seniors or serve Eligible Seniors who reside in a geographic area designated as a Dental HPSA.

4. The review panel shall consider the distribution of funds across the state in recommending grant proposals for awards. The distribution of funds should be based on

the estimated percentage of Eligible Seniors in the state by Area Agency on Aging region as provided by the Department.

8.960.3.C Grant Awards

The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Colorado Dental Health Care Program for Low-Income Seniors.

8.960.3.D Qualified Grantee Responsibilities

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

1. Identify and outreach to Eligible Seniors and Qualified Providers;

2. Demonstrate collaboration with community-based organizations;

3. Ensure that Eligible Seniors receive Covered Dental Care Services efficiently without duplication of services;

4. Maintain records of Eligible Seniors serviced, Covered Dental Care Services provided, and moneys spent for a minimum of six (6) years;

5. Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;

6. Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and

7. Submit an annual report as specified under section 8.960.3.F.

8.960.3.E Invoicing

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors shall submit invoices on a form and schedule specified by the Department. Covered Dental Care Services shall be provided before a Qualified Grantee may submit an invoice to the Department.

1. Invoices shall include the number of Eligible Seniors served, the alphanumeric code and procedure description as listed in Appendix A, and any other information required by the Department.

2. The Department will pay no more than the established Program Payment per procedure rendered, as listed in Appendix A.

3. Eligible Seniors shall not be charged more than the Max Client Co-Pay as listed in Appendix A.

4. Qualified Grantees may invoice for no more than seven (7) percent of the Program Payment for administrative costs.

8.960.3.F Annual Report

On or before September 1, 2016, and each September 1 thereafter, each Qualified Grantee receiving funds from the Colorado Dental Health Care Program for Low-Income Seniors shall submit a report to the Department following the state fiscal year contract period.

The annual report shall be completed in a format specified by the Department and shall include:

1. The number of Eligible Seniors served;

2. The types of Covered Dental Care Services provided;

3. An itemization of administrative expenditures; and

4. Any other information deemed relevant by the Department.

10 CCR 2505-10 § 8.960 APPENDIX A: COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS COVERED SERVICES AND PROCEDURE CODES

Capitalized terms within this appendix shall have the meaning specified in the Definitions section.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodic oral evaluation - established client	D0120	$46.00	$46.00	$0.00	Evaluation performed on a client of record to determine any changes in the client's dental and medical health status since a previous comprehensive or periodic evaluation. This may include an oral cancer evaluation and periodontal evaluation, diagnosis, treatment planning. Frequency: One time per 6 month period per client.
Limited oral evaluation - problem focused	D0140	$62.00	$52.00	$10.00	Evaluation limited to a specific oral health problem or complaint. This code must be used in association with a specific oral health problem or complaint and is not to be used to address situations that arise during multi-visit treatments covered by a single fee, such as, endodontic or post-operative visits related to treatments including prosthesis. Specific problems may include dental emergencies, trauma, acute infections, etc. Cannot be used for adjustments made to prosthesis provided within previous 6 months. Cannot be used as an encounter fee.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive oral evaluation - new or established client	D0150	$81.00	$81.00	$0.00	Evaluation used by general dentist or a specialist when evaluating a client comprehensively. Applicable to new clients; established clients with significant health changes or other unusual circumstances; or established clients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, and an evaluation and recording of the client's dental and medical history and general health assessment. A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0180.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive periodontal evaluation - new or established client	D0180	$88.00	$88.00	$0.00	Evaluation for clients presenting signs & symptoms of periodontal disease & clients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the client's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0150.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - complete series of radiographic images	D0210	$125.00	$125.00	$0.00	Radiographic survey of whole mouth, usually consisting of 14-22 periapical & posterior bitewing images intended to display the crowns & roots of all teeth, periapical areas of alveolar bone. Panoramic radiographic image & bitewing radiographic images taken on the same date of service shall not be billed as a D0210. Payment for additional periapical radiographs within 60 days of a full month series or a panoramic film is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per client. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 must be billed and reimbursed as D0210. Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - periapical first radiographic image	D0220	$25.00	$25.00	$0.00	D0220 one (1) per day per client. Report additional radiographs as D0230. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.
Intraoral - periapical each additional radiographic image	D0230	$23.00	$23.00	$0.00	D0230 must be utilized for additional films taken beyond D0220. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.
Bitewing - single radiographic image	D0270	$26.00	$26.00	$0.00	Frequency: 1 in a 12 month period. Report more than 1 radiographic image as: D0272 two (2); D0273 three (3); D0274 four (4). Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Bitewings - two radiographic images	D0272	$42.00	$42.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - three radiographic images	D0273	$52.00	$52.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - four radiographic images	D0274	$60.00	$60.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Vertical bitewings – seven to eight radiographic images	D0277	$68.32	$68.32	$0.00	Frequency: 1 time in a 12-month period. This does not constitute a full mouth intraoral radiographic series. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Panoramic radiographic image	D0330	$63.00	$63.00	$0.00	Frequency: 1 per 5 years per client. Cannot be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 years.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Prophylaxis - adult	D1110	$88.00	$88.00	$0.00	Removal of plaque, calculus and stains from the tooth structures with intent to control local irritational factors. Frequency: • 1 time per 6 calendar months; 2 week window accepted. • May be billed for routine prophylaxis. • D1110 may be billed with D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth not receiving nonsurgical periodontal therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease. D1110 can only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed. • May be alternated with D4910 for maintenance of periodontally-involved individuals. • D1110 cannot be billed on the same day as D4346 • Cannot be used as 1 month re-

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Topical application of fluoride varnish	D1206	$52.00	$52.00	$0.00	Topical fluoride application is to be used in conjunction with prophylaxis or preventive appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. Cannot be used with D1208.
Topical application of fluoride - excluding varnish	D1208	$52.00	$52.00	$0.00	Any fluoride application, including swishing, trays or paint on variety, to be used in conjunction with prophylaxis or preventive appointment. Frequency: one (1) time per 12 calendar months. Cannot be used with D1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
Amalgam - one surface, primary or permanent	D2140	$107.00	$97.00	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - two surfaces, primary or permanent	D2150	$138.00	$128.00	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Amalgam - three surfaces, primary or permanent	D2160	$167.00	$157.00	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - four or more surfaces, primary or permanent	D2161	$203.00	$193.00	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, anterior	D2330	$115.00	$105.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - two surfaces, anterior	D2331	$146.00	$136.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	$179.00	$169.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	$212.00	$202.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, posterior	D2391	$134.00	$124.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite -two surfaces, posterior	D2392	$176.00	$166.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	$218.00	$208.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces, posterior	D2394	$268.00	$258.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - porcelain/ceramic	D2740	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to high noble metal	D2750	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to predominantly base metal	D2751	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - porcelain fused to noble metal	D2752	$780.00	$730.00	$50.00	Only one the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 cast predominantly base metal	D2781	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 cast noble metal	D2782	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - 3/4 porcelain/ceramic	D2783	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast high noble metal	D2790	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast predominantly base metal	D2791	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - full cast noble metal	D2792	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - titanium	D2794	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	$87.00	$77.00	$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	$89.00	$79.00	$10.00	Not allowed within 6 months of placement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Core buildup, including any pins when required	D2950	$225.00	$200.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. Not payable on the same tooth and same day as D2951.
Pin retention per tooth	D2951	$50.00	$40.00	$10.00	Pins placed to aid in retention of restoration. Can only be used in combination with a multi-surface amalgam.
Cast post and core in addition to crown	D2952	$332.00	$307.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Prefabricated post and core in addition to crown	D2954	$269.00	$244.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Core is built around a prefabricated post. This procedure includes the core material and refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	$566.40	$516.40	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 6-11 and 22-27.
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	$661.65	$611.65	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 4, 5, 12, 13, 20, 21, 28, and 29.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Endodontic therapy, molar tooth (excluding final restoration)	D3330	$786.31	$736.31	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 2, 3, 14, 15, 18, 19, 30, and 31.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	$177.00	$167.00	$10.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. D4341 and D1110 can be reported on same service date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 can only be charged once, not per quadrant; A diagnosis of periodontitis with clinical attachment loss (CAL) included. Diagnosis and classification of the periodontology case type must be in accordance with documentation as currently established by the American Academy of Periodontology. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting. Documentation of other treatment provided at same time will be requested. • Cannot be

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	$128.00	$128.00	$0.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. D4342 and D1110 can be reported on same service date when date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 can only be charged once, not per quadrant; A diagnosis of periodontitis with clinical attachment loss (CAL) included. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting.. Documentation of other treatment provided at same time will be requested. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	D4346	$102.00	$92.00	$10.00	The removal of plaque, calculus, and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures. Frequency: once in a lifetime. • Any follow-up and re-evaluation are included in the initial reimbursement. • Cannot be charged on the same date as D1110, D4341, D4342, or D4910.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit	D4355	$9280.8106	$8270.8106	$10.00	One of (D4335) per 3 year(s) per patient. Prophylaxis D1110 is not reimbursable when provided on the same day of service as D4355. D4355 is not reimbursable if patient record indicates D1110 or D4910 have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as D4355.
Periodontal maintenance procedures	D4910	$136.00	$136.00	$0.00	Procedure following periodontal therapy D4341 or D4342. This procedure includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. Frequency: • Up to four times per fiscal year per client. • Cannot be charged on the same date as D4346. • Cannot be charged within the first three months following active periodontal treatment.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - maxillary	D5110	$862.98~~793.00~~	$782.98~~13.00~~	$80.00	Reimbursement made upon delivery of a complete maxillary denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130 or D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	$864.38~~793.00~~	$784.38~~13.00~~	$80.00	Reimbursement made upon delivery of a complete mandibular denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130, D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – maxillary	D5130	$862.98~~793.00~~	$782.98~~13.00~~	$80.00	Reimbursement made upon delivery of an immediate maxillary denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5130 can be reimbursed only once per lifetime per client. Complete denture, D5110, may be considered 5 years after immediate denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – mandibular	D5140	$864.38~~793.00~~	$784.38~~13.00~~	$80.00	Reimbursement made upon delivery of an immediate mandibular denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5140 can be reimbursed only once per lifetime per client. Complete dentures, D5120, may be considered 5 years after immediate denture was reimbursed – documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5211	$700.00	$640.00	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5211 and D5212 are considered definitive treatments. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin maxillary per every 3 years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5212	$778.00	$718.00	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5211 and D5212 are considered definitive treatment. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin mandibular per every 3 years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213	$~~77~~832.92~~.00~~	$772.92~~18.00~~	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can also be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	$~~77~~832.92~~.00~~	$772.92~~18.00~~	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	D5221	$5~~0~~99.66~~.00~~	$539.66~~449.00~~	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5221 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	D5222	$5~~0~~99.66~~.00~~	$539.66~~449.00~~	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5222 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5223	$832.92~~778.00~~	$772.92~~18.00~~	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5223 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5224	$~~77~~832.92~~.00~~	$772.92~~18.00~~	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5224 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.
Repair broken complete denture base, mandibular	D5511	$122.05~~87.00~~	$112.05~~77.00~~	$10.00	Repair broken complete denture base, mandibular
Repair broken complete denture base, maxillary	D5512	$~~87.00~~122.05	$~~77.00~~112.05	$10.00	Repair broken complete denture base, maxillary

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Replace missing or broken teeth - complete denture (each tooth)	D5520	$91.7173.00	$81.7163.00	$10.00	Replacement/repair of missing or broken teeth.
Repair resin partial denture base, mandibular	D5611	$95.00	$85.00	$10.00	Repair resin partial denture base, mandibular
Repair resin partial denture base, maxillary	D5612	$95.00	$85.00	$10.00	Repair resin partial denture base, maxillary
Repair cast partial framework, mandibular	D5621	$119.6887.00	$109.6877.00	$10.00	Repair cast partial framework, mandibular
Repair cast partial framework, maxillary	D5622	$119.6887.00	$109.6877.00	$10.00	Repair cast partial framework, maxillary
Repair or replace broken retentive/clasping materials – per tooth	D5630	$129.243.00	$119.243.00	$10.00	Repair of broken clasp on partial denture base – per tooth.
Replace broken teeth-per tooth	D5640	$92.8180.00	$82.8170.00	$10.00	Repair/replacement of missing tooth.
Add tooth to existing partial denture	D5650	$109.00	$99.00	$10.00	Adding tooth to partial denture base. Documentation may be requested when charged on partial delivered in last 12 months.
Add clasp to existing partial denture	D5660	$134.221.00	$124.221.00	$10.00	Adding clasp to partial denture base – per tooth. Documentation may be requested when charged on partial delivered in last 12 months.
Rebase complete maxillary denture	D5710	$322.00	$297.00	$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Rebase complete mandibular denture	D5711	$322.00	$297.00	$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase maxillary partial denture	D5720	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase mandibular partial denture	D5721	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Reline complete maxillary denture (chairside)	D5730	$182.00	$172.00	$10.00	Chair side reline that resurfaces without processing denture base. Frequency: One (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Reline complete mandibular denture (chairside)	D5731	$182.00	$172.00	$10.00	Chair side reline that resurfaces without processing denture base. Frequency: One (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (chairside)	D5740	$1~~6~~73.42~~.00~~	$163.42~~57.00~~	$10.00	Chair side reline that resurfaces without processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (chairside)	D5741	$1~~6~~75.06~~.00~~	$165.06~~57.00~~	$10.00	Chair side reline that resurfaces without processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete maxillary denture (laboratory)	D5750	$243.00	$218.00	$25.00	Laboratory reline that resurfaces with processing denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Reline complete mandibular denture (laboratory)	D5751	$243.00	$218.00	$25.00	Laboratory reline that resurfaces with processing denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (laboratory)	D5760	$239.00	$214.00	$25.00	Laboratory reline that resurfaces with processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (laboratory)	D5761	$239.00	$214.00	$25.00	Laboratory reline that resurfaces with processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	$110.30~~82.00~~	$100.30~~72.00~~	$10.00	Routine removal of tooth structure, including minor smoothing of socket bone, and closure as necessary. Treatment notes must include documentation that an extraction was done per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$170.52~~35.00~~	$1~~2~~60.52~~5.00~~	$10.00	Includes removal of bone, and/or sectioning of erupted tooth, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth.
Removal of impacted tooth-soft tissue	D7220	$204.54~~178.40~~	$15~~8~~4.54~~.40~~	$20.00	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32 One of D7220 per 1 lifetime per patient per tooth
Removal of impacted tooth-partially bony	D7230	$252.11~~24.39~~	$232.11~~04.39~~	$20.00	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32 One of D7230 per 1 lifetime per patient per tooth
Removal of impacted tooth-completely bony	D7240	$292.37~~63.31~~	$272.37~~43.31~~	$20.00	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32 One of D7240 per 1 lifetime per patient per tooth.
Removal of impacted tooth-completely boney, with unusual surgical complications	D7241	$385~~3~~.84~~1.75~~	$363.84~~31.75~~	$20.00	Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Teeth 1-32 One of D7241 per lifetime per patient per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Surgical removal of residual tooth roots (cutting procedure)	D7250	$179.8043.00	$169.8033.00	$10.00	Includes removal of bone, and/or sectioning of residual tooth roots, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth. Can only be charged once per tooth. Cannot be charged for removal of broken off roots for recently extracted tooth.
Incisional biopsy of oral tissue-soft	D7286	$381.00	$381.00	$0.00	Removing tissue for histologic evaluation. Treatment notes must include documentation and proof that biopsy was sent for evaluation.
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	$150.00	$140.00	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	$138.00	$128.00	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	$197.7150.00	$187.7140.00	$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	$197.7138.00	$1287.71.00	$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Removal of lateral exostosis (maxilla or mandible)	D7471	$286.043.31	$276.043.31	$10.00	Removal of a benign bony outgrowth (bone spur) for proper prosthesis fabrication. Reported per arch.
Removal of torus palatinus	D7472	$336.2708.00	$326.2798.00	$10.00	To remove a malformation of bone for proper prosthesis fabrication.
Removal of torus mandibularis	D7473	$3208.000.00	$318.00290.00	$10.00	To remove a malformation of bone for proper prosthesis fabrication.
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins.
Palliative (emergency) treatment of dental pain - minor procedure	D9110	$77.4761.00	$52.4736.00	$25.00	Emergency treatment to alleviate pain/discomfort. This code cannot be used for filing claims or writing or calling in a prescription to the pharmacy or to address situations that arise during multi-visit treatments covered by a single fee such as surgical or endodontic treatment. Report per visit, no procedure. Frequency: Limit 1 time per year. Maintain documentation that specifies problem and treatment.
Evaluation for moderate sedation, deep sedation or general anesthesia	D9219	$40.338.916	$40.338.916	$0.00	One of D9219 or D9310 per 12 month(s) per provider or location
Deep sedation/general anesthesia-each 15 minute increment	D9223	$102.0588.99	$92.0578.99	$10.00	Ten of D9223 per 1 day per patient. Not allowed with D9243

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intravenous moderate (conscious)sedation/analgesia-each 15 minute increment	D9243	$102.05~~88.99~~	$92.05~~78.99~~	$10.00	Fourteen of D9243 per 1 day per patient. Not allowed with D9223

EXPLANATION OF RESTORATIONS		
Location	Number of Surfaces	Characteristics
Anterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Incisal, Lingual, or Labial.
	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial–Lingual.
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual–Mesial–Labial.
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Incisal-Lingual-Labial.
Posterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Occlusal, Lingual, or Buccal.
	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial-Occlusal.
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual-Occlusal-Distal.
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Occlusal-Lingual-Distal.

NOTE: Tooth surfaces are reported using the letters in the following table.

Surface	Code
Buccal	B
Distal	D
Facial (or Labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O