

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Special Financing rule concerning the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960  
Rule Number: MSB 21-08-26-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 21-08-26-A, Revision to Medical Assistance Special Financing rule concerning the 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):  
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)?  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

**PUBLICATION INSTRUCTIONS\***

Replace the current text at Appendix A with the proposed text beginning at Appendix A through the end of Appendix A. This rule is effective December 30, 2021.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Special Financing rule concerning the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960

Rule Number: MSB 21-08-26-A

Division / Contact / Phone: Special Financing / Chandra Vital / 303-866-5506

## 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).

Current rule states that no procedures under the Dental Health Care Program for Low-Income Seniors may be below the Health First Colorado dental payment. Health First Colorado increased the dental rates effective July 1, 2021, and 43 procedures of the Dental Health Care Program for Low-Income Seniors fell below the Health First Colorado dental payment. This rule change will increase the 43 procedures in Appendix A to match the current rate being paid by Health First Colorado.

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:

The program's statute requires that rates for dental procedures for the Dental Health Care Program for Low-Income Seniors are at least as much as Medicaid's dental rates. Rule changes are necessary to revise rates to meet the statutory requirement.

3. Federal authority for the Rule, if any:

45 C.F.R. 162-1002(a)(4)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);  
Sections 25.5-3-404(4), C.R.S. (2021)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Special Financing rule concerning the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960

Rule Number: MSB 21-08-26-A

Division / Contact / Phone: Special Financing / Chandra Vital / 303-866-5506

## 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.

Revising rates for the 43 dental procedures in Appendix A will have no negative impacts on eligible seniors and the grantees of the Dental Health Care Program for Low-Income Seniors will receive the accurate payment according to rule.

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 change in the 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 Dental Health Care Program for Low-Income Seniors has a fixed appropriation and the changing of the program rates for the 43 procedures in Appendix A 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.

Revising the rates for the 43 procedures in Appendix A will ensure the Department is following the statutory requirements and the grantees of the program will receive the correct payment amount.

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 ensure that the Department is following state statute which requires the program's rates are at least as much as Medicaid's dental rates.

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 follow statute and no alternatives are available.

## DO NOT PUBLISH THIS PAGE

### **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. (2020).

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 or client is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans. 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).

## DO NOT PUBLISH THIS PAGE

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. (2020).

Medicare means the federal health insurance program for people who are 65 or older; certain younger people with disabilities; or people with End-Stage Renal Disease.

Medicare Advantage Plans mean the plans offered by Medicare-approved private companies that must follow rules set by Medicare and may provide benefits for services Medicare does not, such as vision, hearing, and dental care.

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. (2020).

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. (2020);
2. A community-based organization or foundation;

## DO NOT PUBLISH THIS PAGE

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. (2020).

### **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. (2020).

### **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

## DO NOT PUBLISH THIS PAGE

- 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. For Eligible Seniors with dental coverage through a Medicare Advantage Plan, bill the Medicare Advantage Plan for dental procedures covered by the Medicare Advantage Plan prior to seeking payment from the Department. The Colorado Dental Health Care Program is secondary to the Medicare Advantage Plan dental coverage;
6. Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;
7. Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and
8. 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.



**DO NOT PUBLISH THIS PAGE**

3. Eligible Seniors shall not be charged more than the Max Client Co-Pay as listed in Appendix A.
4. Qualified Grantees shall not bill the Department for any procedures covered by Medicare Advantage Plans that have been billed and paid by the Medicare Advantage Plans;
5. Qualified Grantees shall indicate on the invoice if the Eligible Senior has dental coverage through a Medicare Advantage Plan and any claim to the Medicare Advantage Plan was adjudicated prior to billing the Department;
6. 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;
4. The procedures and amounts billed to Medicare Advantage Plans for Eligible Seniors;  
and
5. Any other information deemed relevant by the Department.

DO NOT PUBLISH THIS PAGE

**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.

DO NOT PUBLISH THIS PAGE

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	<p>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.</p>

DO NOT PUBLISH THIS PAGE

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	<p>Evaluation for clients presenting signs &amp; symptoms of periodontal disease &amp; 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.</p>

DO NOT PUBLISH THIS PAGE

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	<p>Radiographic survey of whole mouth, usually consisting of 14-22 periapical &amp; posterior bitewing images intended to display the crowns &amp; roots of all teeth, periapical areas of alveolar bone. Panoramic radiographic image &amp; 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.</p>

DO NOT PUBLISH THIS PAGE

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.

DO NOT PUBLISH THIS PAGE

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.

DO NOT PUBLISH THIS PAGE

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.



DO NOT PUBLISH THIS PAGE

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	<p>Removal of plaque, calculus and stains from the tooth structures with intent to control local irritational factors. Frequency:</p> <ul style="list-style-type: none"> <li>• 1 time per 6 calendar months; 2 week window accepted.</li> <li>• May be billed for routine prophylaxis.</li> <li>• 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.</li> <li>• May be alternated with D4910 for maintenance of periodontally-involved individuals.</li> <li>• D1110 cannot be billed on the same day as D4346</li> <li>• Cannot be used as 1 month re-</li> </ul>

DO NOT PUBLISH THIS PAGE

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.
Interim caries arresting medicament application – per tooth	D1354	\$5. <del>6047</del>	\$5. <del>6047</del>	\$0.00	Two of D1354 per 12 months per patient per tooth for primary and permanent teeth. Not to exceed 4 times per tooth in a lifetime. Cannot be billed on the same day as D1355 or any D2000 series code (D2140–D2954). Must Report both tooth number and surface(s).

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Caries preventive medicament application – per tooth	D1355	\$5.47	\$5.47	\$0.00	For primary prevention or remineralization. Medicaments applied do not include topical fluorides. Medicaments that may be applied during the delivery of D1355 procedure include Silver Diamine Fluoride (SDF), Silver Nitrate (SN), thymol-CHX varnish, and topical povidone iodine (PVP-I). Cannot be billed on the same day as: D1206, D1208, D1354, D0140, D9110, or any restoration codes on the same day or within 12 months of D2140 thru D2954. Maximum of four D1355 per tooth per lifetime. Must report both tooth number and surface(s).
Amalgam - one surface, primary or permanent	D2140	<del>\$112.6797.00</del>	<del>\$102.6797.00</del>	\$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	<del>\$141.2038.00</del>	<del>\$131.2028.00</del>	\$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.

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Amalgam - three surfaces, primary or permanent	D2160	\$ <del>170.8867.00</del>	\$ <del>160.8857.00</del>	\$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	\$ <del>204.963.00</del>	\$ <del>194.963.00</del>	\$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.

DO NOT PUBLISH THIS PAGE

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.

DO NOT PUBLISH THIS PAGE

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.

DO NOT PUBLISH THIS PAGE

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.

DO NOT PUBLISH THIS PAGE

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.



DO NOT PUBLISH THIS PAGE

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.

DO NOT PUBLISH THIS PAGE

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 extracoronar 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.

DO NOT PUBLISH THIS PAGE

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.

DO NOT PUBLISH THIS PAGE

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.

DO NOT PUBLISH THIS PAGE

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	<p>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:</p> <ul style="list-style-type: none"> <li>• 1 time per quadrant per 36 month interval.</li> <li>• 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.</li> <li>• Cannot be</li> </ul>

DO NOT PUBLISH THIS PAGE

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	<p>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:</p> <ul style="list-style-type: none"> <li>• 1 time per quadrant per 36 month interval.</li> <li>• 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.</li> <li>• Cannot be charged on same date as D4346.</li> <li>• Any follow-up and re-evaluation are included in the initial reimbursement.</li> </ul>

DO NOT PUBLISH THIS PAGE

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	<p>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.</p> <ul style="list-style-type: none"> <li>• Any follow-up and re-evaluation are included in the initial reimbursement.</li> <li>• Cannot be charged on the same date as D1110, D4341, D4342, or D4910.</li> </ul>

DO NOT PUBLISH THIS PAGE

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	<del>\$94,022.84</del>	<del>\$84,022.84</del>	\$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	<p>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:</p> <ul style="list-style-type: none"> <li>• Up to four times per fiscal year per client.</li> <li>• Cannot be charged on the same date as D4346.</li> <li>• Cannot be charged within the first three months following active periodontal treatment.</li> </ul>



DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - maxillary	D5110	<del>\$874.52</del> 62.98	<del>\$794.52</del> 82.98	\$80.00	<p>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.</p>

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	<del>\$875.94</del> 64.38	<del>\$795.94</del> 84.38	\$80.00	<p>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.</p>

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – maxillary	D5130	<del>\$874.5262.98</del>	<del>\$794.5282.98</del>	\$80.00	<p>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.</p>

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – mandibular	D5140	<del>\$875.9464.38</del>	<del>\$795.9484.38</del>	\$80.00	<p>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.</p>

DO NOT PUBLISH THIS PAGE

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	<p>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 <u>after</u> 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.</p>

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture - resin base (including retentive/clasping rests, and teeth)	D5212	\$778.00	\$718.00	\$60.00	<p>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 <u>after</u> 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.</p>

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
<p>Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</p>	D5213	<del>\$844.3132-92</del>	<del>\$784.3172-92</del>	\$60.00	<p>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.</p>

DO NOT PUBLISH THIS PAGE

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	<del>\$844.3132.92</del>	<del>\$784.3172.92</del>	\$60.00	<p>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.</p>



DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
<p>Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)</p>	D5221	<del>\$607.61</del> 599.66	<del>\$547.61</del> 39.66	\$60.00	<p>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.</p>

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
<p>Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)</p>	<p>D5222</p>	<p><del>\$607.61</del> <del>599.66</del></p>	<p><del>\$547.61</del> <del>39.66</del></p>	<p>\$60.00</p>	<p>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.</p>

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
<p>Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</p>	D5223	<del>\$844.31</del> <u>32.92</u>	<del>\$784.31</del> <u>72.92</u>	\$60.00	<p>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.</p>

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
<p>Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</p>	D5224	<del>\$844.3132.92</del>	<del>\$784.3172.92</del>	\$60.00	<p>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.</p>
<p>Repair broken complete denture base, mandibular</p>	D5511	<del>\$123.702.05</del>	<del>\$113.702.05</del>	\$10.00	<p>Repair broken complete denture base, mandibular</p>
<p>Repair broken complete denture base, maxillary</p>	D5512	<del>\$123.702.05</del>	<del>\$113.702.05</del>	\$10.00	<p>Repair broken complete denture base, maxillary</p>
<p>Replace missing or broken teeth - complete denture (each tooth)</p>	D5520	<del>\$92.914.74</del>	<del>\$82.914.74</del>	\$10.00	<p>Replacement/repair of missing or broken teeth.</p>

DO NOT PUBLISH THIS PAGE

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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	<del>\$121.2949.68</del>	<del>\$111.2909.68</del>	\$10.00	Repair cast partial framework, mandibular
Repair cast partial framework, maxillary	D5622	<del>\$121.2949.68</del>	<del>\$111.2909.68</del>	\$10.00	Repair cast partial framework, maxillary
Repair or replace broken retentive/clasping materials – per tooth	D5630	<del>\$131.0029.24</del>	<del>\$121.0049.24</del>	\$10.00	Repair of broken clasp on partial denture base – per tooth.
Replace broken teeth-per tooth	D5640	<del>\$94.022.81</del>	<del>\$84.022.81</del>	\$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	<del>\$136.054.22</del>	<del>\$126.054.22</del>	\$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.

DO NOT PUBLISH THIS PAGE

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.

DO NOT PUBLISH THIS PAGE

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	\$17 <del>5.823.42</del>	\$165 <del>.823.42</del>	\$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	\$177 <del>.495.06</del>	\$167 <del>.495.06</del>	\$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.

DO NOT PUBLISH THIS PAGE

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	\$ <del>111.780.30</del>	\$ <del>101.780.30</del>	\$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.



DO NOT PUBLISH THIS PAGE

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	\$172,880.52	\$162,880.52	\$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	\$207,254.54	\$187,254.54	\$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	\$255,532.14	\$235,532.14	\$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	\$296,382.37	\$276,382.37	\$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 bony, with unusual surgical complications	D7241	\$389,203.84	\$369,203.84	\$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.

DO NOT PUBLISH THIS PAGE

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	<del>\$182.30</del> <del>79.80</del>	<del>\$172.30</del> <del>69.80</del>	\$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.
Alveoplasty 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.
Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	<del>\$139.42</del> <del>8.00</del>	<del>\$129.42</del> <del>8.00</del>	\$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	<del>\$200.47</del> <del>197.71</del>	<del>\$190.47</del> <del>87.71</del>	\$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.

DO NOT PUBLISH THIS PAGE

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	<del>\$200.47197.71</del>	<del>\$190.4787.71</del>	\$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Removal of lateral exostosis (maxilla or mandible)	D7471	<del>\$290.1186.04</del>	<del>\$280.1176.04</del>	\$10.00	Removal of a benign bony outgrowth (bone spur) for proper prosthesis fabrication. Reported per arch.
Removal of torus palatinus	D7472	<del>\$341.0836.27</del>	<del>\$331.0826.27</del>	\$10.00	To remove a malformation of bone for proper prosthesis fabrication.
Removal of torus mandibularis	D7473	<del>\$332.6928.00</del>	<del>\$322.6918.00</del>	\$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	<del>\$78.237.47</del>	<del>\$53.232.47</del>	\$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	<del>\$40.9031</del>	<del>\$40.9031</del>	\$0.00	One of D9219 or D9310 per 12 month(s) per provider or location
Deep sedation/general anesthesia-each 15 minute increment	D9223	<del>\$103.402.05</del>	<del>\$93.402.05</del>	\$10.00	Ten of D9223 per 1 day per patient. Not allowed with D9243

DO NOT PUBLISH THIS PAGE

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	\$ <del>103,402.05</del>	\$ <del>93,402.05</del>	\$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-Incisor-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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning General and Citizenship Eligibility Requirements, Section 8.100.3.G  
Rule Number: MSB 21-08-27-A  
Division / Contact / Phone: Eligibility Policy Section / Jennifer VanCleave / 303-866-6204

**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 21-08-27-A, Revision to the Medical Assistance Eligibility Rules Concerning General and Citizenship Eligibility Requirements, Section 8.100.3.G
3. This action is an adoption of: <Select One>
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):  
Sections(s) OP Pages, 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)? <Select One>  
If yes, state effective date:  
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

**PUBLICATION INSTRUCTIONS\***

Replace the current text at 8.100.3.G.1.g.iv with the proposed language beginning at 8.100.3.G.1.g.iv through the end of 8.100.3.G.1.g.iv. This rule is effective December 30, 2021.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning General and Citizenship Eligibility Requirements, Section 8.100.3.G

Rule Number: MSB 21-08-27-A

Division / Contact / Phone: Eligibility Policy Section / Jennifer VanCleave / 303-866-6204

## 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 rule change will amend 10 CCR 2505-10 §8.100.3.G to update General Medical Assistance Eligibility and Citizenship Requirements to include Compact of Free Associate (COFA) migrants as eligible non-citizens not subject to a 5-year waiting period. Effective December 27, 2020, section 208 of the Consolidated Appropriations Act of 2021 requires states and the District of Columbia to provide Medicaid coverage for COFA individuals. COFA is an agreement between the United States and the three Pacific Island sovereign states of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau; also known as Freely Associated States. States must cover COFA migrants in Medicaid as qualified non-citizens without a 5-year waiting period they are otherwise eligible under the Medicaid state plan or section 1115 demonstration.

Eligibility rules at §8.100.3.G.1.g.vi.12 already allow for Medicaid eligibility without a 5-year waiting period for COFA individuals (Micronesia, Marshall Islands, Palau) that are pregnant women, and for children under the age of 19 years. The proposed rule will allow all COFA individuals to be considered qualified non-citizens without a 5-year waiting period, regardless of age or pregnancy. The Centers for Medicare and Medicaid Services (CMS) have provided guidance that the expanded eligibility to this population cannot begin prior to the enactment date of the Consolidated Appropriations Act of 2021. Eligibility for these individuals can begin as early as December 27, 2020. The proposed change will only update rule to consider all COFA individuals as eligible non-citizens. These individuals will still need to meet all other categorical requirement to be eligible for and approved for Medicaid (income, assets, disability, level of care, etc.) based on category.

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:

The Consolidated Appropriations Act of 2021 has been in effect since December 27, 2020. CMS recently provided guidance for rule and system updates that are required as soon as possible, as the Department is currently out of compliance with federal law. The Colorado

DO NOT PUBLISH THIS PAGE

Benefit Management System (CBMS) will be updated at next available system build on August 7, 2021, so rule must be updated to ensure systematic and regulatory alignment.

2. Federal authority for the Rule, if any:

Consolidated Appropriations Act 2021, Section 208; 42 C.F.R. §435.406

3. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

Section 25.5-4-205, C.R.S. (2021)

Section 24.4-4-103(6)(a), C.R.S. (2021)

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning General and Citizenship Eligibility Requirements, Section 8.100.3.G

Rule Number: MSB 21-08-27-A

Division / Contact / Phone: Eligibility Policy Section / Jennifer VanCleave / 303-866-6204

## **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.

With the proposed rule change, all applicants and recipients of Medical Assistance who are a part of COFA, including the citizens of Micronesia, the Marshall Islands, and Palau will now be considered eligible non-citizens without a 5-year waiting period for the purposes of determining their eligibility. They will also be eligible for full benefits, rather than only those services necessary to treat an emergency medical condition. The Department will benefit from the proposed change as the rule will align with federal requirements. The Department will also bear the cost of the proposed rule change, as there will likely be a small increase in the number of individuals who will be eligible for Medical Assistance.

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 proposed change will update rule to comply with the requirements put forth in Section 208 of the Consolidated Appropriations Act of 2021. The Department will benefit from compliance with federal regulations. This will ensure that the Medical Assistance eligibility will be accurately determined for COFA individuals. The proposed rule change will also expand eligibility for full Medical Assistance benefits to COFA individuals who were previously only eligible for coverage of services necessary to treat an emergency medical condition.

The Department, stakeholders, applicants, members, and the general public will benefit from a clear description of the expanded population eligible for benefits, as well as the date on which the changes were authorized.

CBMS will also be updated to align COFA eligibility determinations with this rule change, as well as to accurately verify immigration status via the Verify Lawful Presence (VLP) interface with the Systematic Alien Verification of Entitlements (SAVE) Program

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 Department anticipates that this rule change will result in an increase of the number of individuals eligible for Medical Assistance. The Department anticipates that the population will be small. Based on current data, there are 555 individuals who have applied for Medicaid and are citizens of Micronesia, the Marshall Islands, or Palau, and are not currently eligible for Medicaid. This is likely an upper bound on the impacted population, as not all of these individuals would otherwise meet Medical Assistance eligibility criteria. If all 555 individuals enrolled in Medicaid, it is projected to cost roughly \$2.4 million total funds, including \$250k General Fund, \$187K cash funds, and \$2.0 million federal funds.

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

The cost of the proposed rule is the costs to cover more members on Medicaid. The benefit of the proposed rule change is to come into compliance with federal law. The cost of inaction is being out of compliance with federal law and risking federal financial participation for Medicaid. The benefit of inaction is to not incur additional costs related to covering more members.

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 or less intrusive methods for complying with federal law.

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.

The Department considered no alternative methods for achieving the purpose of the proposed rule change, as it is required to come into compliance with federal law.

## 8.100 MEDICAL ASSISTANCE ELIGIBILITY

### 8.100.3.G. General and Citizenship Eligibility Requirements

1. To be eligible to receive Medical Assistance, an eligible person shall:
  - a. Be a resident of Colorado;
  - b. Meet the following requirements while being an inmate, in-patient or resident of a public institution:
    - i). The following individuals, if eligible, may be enrolled for Medical Assistance
      1. Patients in a public medical institution
      2. Residents of a Long-Term Care Institution
      3. Prior inmates who have been paroled
      4. Resident of a publicly operated community residence which serves no more than 16 residents
      5. Individuals participating in community corrections programs or residents in community corrections facilities ("halfway houses") who have freedom of movement and association which includes individuals who:
        - a) are not precluded from working outside the facility in employment available to individuals who are not under justice system supervision;
        - b) can use community resources (e.g., libraries, grocery stores, recreation, and education) at will;
        - c) can seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state; and/or
        - d) are residing at their home, such as house arrest, or another location
    - ii). Inmates who are incarcerated in a correctional institution such as a city, county, state or federal prison may be enrolled, if eligible, with benefits limited to an in-patient stay of 24 hours or longer in a medical institution.
  - c. Not be a patient in an institution for tuberculosis or mental disease, unless the person is under 21 years of age or has attained 65 years of age and is eligible for the Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement. See section 8.100.4.H for special provisions extending Medical Assistance coverage for certain patients who attain age 21 while receiving such inpatient psychiatric services;

- d. Meet all financial eligibility requirements of the Medical Assistance Program for which application is being made;
- e. Meet the definition of disability or blindness, when applicable. Those definitions appear in this volume at 8.100.1 under Definitions;
- f. Meet all other requirements of the Medical Assistance Program for which application is being made; and
- g. Fall into one of the following categories:
  - i) Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa or Swain's Island; or
  - ii) Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or
  - iii) Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance benefits to begin no earlier than five years after the non-citizen's date of entry into the United States who falls into one of the following categories:
    - 1) lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA");
    - 2) paroled into the United States for at least one year under 8 U.S.C. § 1182(d)(5); or
    - 3) granted conditional entry under section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or
    - 4) determined by the eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. §1641(c), has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Medicaid); or
  - iv) Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:
    - 1) lawfully residing in Colorado and is an honorably discharged military veteran (also includes spouse, unremarried surviving spouse and unmarried, dependent children), or
    - 2) lawfully residing in Colorado and is on active duty (excluding training) in the U.S. Armed Forces (also includes spouse, unremarried surviving spouse and unmarried, dependent children), or
    - 3) granted asylum under section 208 of the INA, or
    - 4) refugee under section 207 of the INA, or

- 5) deportation withheld under section 243(h) (as in effect prior to September 30, 1996) or section 241(b)(3) (as amended by P.L. 104-208) of the INA, or
- 6) Cuban or Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, or
- 7) an individual who (1) was born in Canada and possesses at least 50 percent American Indian blood, or is a member of an Indian tribe as defined in 25 U.S.C. sec. 5304(e)(2016), or
- 8) admitted to the U.S. as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as amended by P.L. 100-461), or
- 9) lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam conflict, or
- 10) a victim of a severe form of trafficking in persons, as defined in section 103 of the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. § 7105(b) (2016)), or
- 11) An alien who arrived in the United States on or after December 26, 2007 who is an Iraqi special immigrant under section 101(a)(27) of the INA, or
- 12) An alien who arrived in the United States on or after December 26, 2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA, ~~or~~
- 13) Compact of Free Association (COFA) migrants, including citizens of Micronesia, the Marshall Islands, and Palau, pursuant to section 208 of the Consolidated Appropriations Act of 2021 (in effect December 27, 2020).

- v) The statutes listed at sections 8.100.3.G.1.g.iii.1-5 and at 8.100.3.G.1.g.iv.3-11 are incorporated herein by reference. No amendments or later editions are incorporated. These regulations are available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Pursuant to C.R.S. 24-4-103(12.5)(b)(2016), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.
- vi) Be a lawfully admitted non-citizen who is a pregnant women or a child under the age of 19 years in the United States who falls into one of the categories listed in 8.100.3.G.1.g.iii or into one of the following categories listed below. These individuals are exempt from the 5-year waiting period:
  - 1) granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a,or

- 2) granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a and pending applicants for TPS granted employment authorization,
  - 3) granted employment authorization under 8 CFR 274a.12(c),or
  - 4) Family Unity beneficiary in accordance with section 301 of Pub. L. 101-649, as amended.
  - 5) Deferred Enforced Departure (DED), pursuant to a decision made by the President,
  - 6) granted Deferred Action status (excluding Deferred Action for Childhood Arrivals (DACA)) as described in the Secretary of Homeland Security's June 15,2012 memorandum,
  - 7) granted an administrative stay of removal under 8 CFR 241.6(2016), or
  - 8) Beneficiary of approved visa petition who has a pending application for adjustment of status.
  - 9) Pending an application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who-
    - a) as been granted employment authorization; or
    - b) Is under the age of 14 and has had an application pending for at least 180 days.
  - 10) granted withholding of removal under the Convention Against Torture,
  - 11) A child who has a pending application for Special Immigrant Juvenile status under 8 U.S.C. 1101(a)(27)(J), or
  - 12) Citizens of Micronesia, the Marshall Islands, and Palau, or
  - 13) is lawfully present American Samoa under the immigration of laws of American Samoa.
  - 14) A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or under 8 U.S.C. 1101(a)(17), or
  - 15) A non-citizen who has been paroled into the United States for less than one year under 8 U.S.C. § 1182(d)(5), except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings.
- vii) Exception: The exception to these requirements is that persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but who are not citizens, and are not eligible non-citizens, according to the criteria set forth in 8.100.3.G.1.g, shall receive Medical Assistance benefits for emergency medical care only. The rules on confidentiality prevent the Department or eligibility site from reporting to the United States Citizenship and Immigration Services persons who have applied for or are receiving assistance.

These persons need not select a primary care physician as they are eligible only for emergency medical services.

For non-qualified aliens receiving Medical Assistance emergency only benefits, the following medical conditions will be covered:

An emergency medical condition (including labor and delivery) which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- 1) placing the patient's health in serious jeopardy;
- 2) serious impairment of bodily function; or
- 3) serious dysfunction of any bodily organ or part.

A physician shall make a written statement certifying the presence of an emergency medical condition when services are provided and shall indicate that services were for a medical emergency on the claim form. Coverage is limited to care and services that are necessary to treat immediate emergency medical conditions. Coverage does not include prenatal care or follow-up care.

2. For determinations of eligibility for Medical Assistance, legal immigration status must be verified. This requirement applies to a non-citizen individual who meets the criteria of any category defined at 8.100.3.G(1)(g)(ii) (iii) (iv) or (vi) and has declared that he or she has a legal immigration status.
  - a. The Verify Lawful Presence (VLP) interface will be used to verify immigration status. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) Program to verify legal immigration status.
    - i) If an automated response from VLP confirms that the information submitted is consistent with VLP data for immigration status verification requirements, no further action is required for the individual and no additional documentation of immigration status is required.
    - ii) If the VLP cannot automatically confirm the information submitted, the individual will be contacted with a request for additional documents and/or information needed to verify their legal immigration status through the VLP interface. If a response from the VLP interface confirms that the additional documents and/or information received from the individual verifies their legal immigration status, no further action is required for the individual and no additional documentation of immigration status is required.
3. Reasonable Opportunity Period
  - a. If the verification through the electronic interface is unsuccessful then the applicant will be provided a reasonable opportunity period, of 90 days, to submit documents indicating a legal immigration status, as listed in 8.100.3.G.1.g. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period.

- b If the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.
- c. The reasonable opportunity period applies to MAGI, Adult and Buy-In Programs.
  - i) For the purpose of this section only, MAGI Programs for persons covered pursuant to 8.100.4.G or 8.100.4.I. include the following:

Commonly Used Program Name	Rule Citation
Children's Medical Assistance	8.100.4.G.2
Parent and Caretaker Relative Medical Assistance	8.100.4.G.3
Adult Medical Assistance	8.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Legal Immigrant Prenatal Medical Assistance	8.100.4.G.6
Transitional Medical Assistance	8.100.4.I.1-5

- ii) For the purpose of this section only, Adult and Buy-In Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715. include the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled Widow/Widower	8.100.3.F.1.e
Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Medicaid Buy-In Program for Working Adults with Disabilities	8.100.6.P
Medicaid Buy-In Program for Children with Disabilities	8.100.6.Q
Breast and Cervical Cancer Program (BCCP)	8.715

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Immunization Services, Section 8.815.

Rule Number: MSB 21-08-28-A

Division / Contact / Phone: Health Program Office / Christina Winship / 303-866-5578

**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 21-08-28-A, Revision to the Medical Assistance Act Rule concerning Immunization Services, Section 8.815.

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) 8.815, 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)?

If yes, state effective date:

Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

**PUBLICATION INSTRUCTIONS\***

Replace the current text at 8.815 with the proposed text beginning at 8.815.1 through the end of 8.815.1. Replace the current text at 8.815.3 with the proposed text beginning at 8.815.3.A through the end of 8.815.3.A. Replace the current text at 8.815.4 beginning at 8.815.4.A through the end of 8.815.4.C. Replace the current text at 8.815.6 with the proposed text beginning at 8.815.6 through the end of 8.815.6. This rule is effective December 30, 2021.

\*to be completed by MSB Board Coordinator



**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Immunization Services, Section 8.815.

Rule Number: MSB 21-08-28-A

Division / Contact / Phone: Health Program Office / Christina Winship / 303-866-5578

**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).

This rule revision is required for the Department to comply with section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136. Specifically, the Department must reimburse providers for COVID-19 testing services and treatments, including vaccines and the administration of such vaccines, provided to Medicaid enrollees. The Department will otherwise no longer qualify for the temporary 6.2 percentage point increase to the Federal Medical Assistance Percentage (FMAP) (the federal government's contribution toward Colorado's Medicaid expenditure) and will be subject to clawback. Current Department policy limits reimbursement for vaccine administration to members 18 and under exclusively through the Vaccines for Children (VFC) program. This revision will allow the Department to reimburse providers for pediatric administration of any and all vaccines provided free of cost by the federal government.

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:

This revision is necessary to comply with section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136. This provision requires the Department to be able to reimburse for administration of the COVID-19 vaccine currently being developed.

3. Federal authority for the Rule, if any:

Section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136

**DO NOT PUBLISH THIS PAGE**

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

## **DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Immunization Services, Section 8.815.

Rule Number: MSB 21-08-28-A

Division / Contact / Phone: Health Program Office / Christina Winship / 303-866-5578

### **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.

Health First Colorado members aged 18 and under, and providers licensed to administer vaccines, will benefit from the flexibility provided by this rule revision for providers to administer the COVID-19 vaccine regardless of whether it's distributed specifically through the Vaccines for Children (VFC) program. Current policy limits reimbursement to pediatric vaccines provided through VFC. There are no actual costs anticipated due to this change to members, providers, or the Department.

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 impact to the Department is the avoidance of federal noncompliance and clawback of the increased FMAP percentage. For members aged 18 and under, this revision ensures timely access to the COVID-19 vaccine. This will also expand the number of providers eligible for reimbursement for administration of the COVID-19 vaccine.

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 associated costs to the Department or any other agency for the implementation and enforcement of the proposed rule. This revision is anticipated to be budget neutral.

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

The benefit of the proposed rule is federal compliance and expansion of COVID-19 vaccine administration to the pediatric population. The cost of inaction would be exposure to the risk of clawback of the enhanced FMAP claimed by the Department during the Public Health Emergency and a smaller pool of providers eligible to administer the COVID-19 vaccine to the pediatric population.

**DO NOT PUBLISH THIS PAGE**

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 or intrusive methods to achieve 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.

There are no alternative methods for achieving the purpose of the proposed rule because the current rule language is explicit in restricting eligible providers for the pediatric population to those participating in the VFC program.

## 8.815 IMMUNIZATION SERVICES

### 8.815.1 Definitions

- 8.815.1.A. Advisory Committee on Immunization Practices (ACIP) means ~~the~~ group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. ACIP was established under Section 222 of the Public Health Service Act (42 U.S.C. § 217a).
- 8.815.1.B. Immunization means the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine.
- 8.815.1.C. School District means any board of cooperative services established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado ~~S~~chool for the ~~e~~Deaf and ~~b~~Blind, created in article 80 of title 22, C.R.S., and any public ~~s~~School ~~e~~District organized under the laws of Colorado except a junior college district.
- 8.815.1.D. Vaccine means a biological preparation that improves immunity to a particular disease.
- 8.815.1.E. Vaccine Administration Services means the provision of an injection, nasal absorption, or oral administration of a vaccine product.
- 8.815.1.F. Vaccines for Children (VFC) means ~~the~~ federally funded program administered through the Centers for Disease Control for the purchase and distribution of pediatric vaccines to program-registered providers for the Immunization of vaccine-eligible children 18 years of age and younger.

### 8.815.2 Client Eligibility

- 8.815.2.A. All Colorado Medicaid clients are eligible for Immunization and Vaccine Administration Services.

### 8.815.3 Provider Eligibility

#### 8.815.3.A. Rendering Providers

1. Colorado Medicaid enrolled providers are eligible to administer Vaccines and Vaccine Administration Services as follows:
  - a. If it is within the scope of the provider's practice;
  - b. In accordance with the requirements at 10 CCR 2505-10, Section 8.200.2.; and
  - c. If the provider is administering Vaccines and Vaccine Administration Services to a client 18 years of age or younger, the provider is using Vaccines provided free of cost by the federal government, including through the ~~must also be enrolled as a-VFC- program provider.~~

#### 8.815.3.B. Prescribing Providers

1. Colorado Medicaid enrolled providers are eligible to prescribe Vaccines and Vaccine Administration Services in accordance with Section 8.815.3.A.1.a.-b.

#### **8.815.4 Covered Services**

8.815.4.A. Vaccines identified in the ACIP Vaccine Recommendations and Guidelines are updated routinely and are covered as follows:

1. For clients 18 years of age and younger, Vaccines are either provided through the VFC program or are otherwise provided without cost by the federal government. ~~are covered by the VFC program.~~
2. For clients 19 years of age and older, Vaccines are covered by Colorado Medicaid.

8.815.4.B. Administration of Vaccines identified in the ACIP Vaccine Recommendations and Guidelines is a covered service for all clients.

8.815.4.C. Immunization and Vaccine Administration Services that are provided by home health agencies, physicians, or other non-physician practitioners to ~~groups of~~ clients at nursing facilities, group homes, or residential treatment centers ~~that are provided by home health agencies, physicians, or other non-physician practitioners~~ are covered only as follows:

1. Immunization services for Cclients who are residents of nursing facilities and clients receiving home health services ~~may receive Immunization services~~ are covered only if ordered by their physician. The skilled nursing component for Immunization administration provided at a nursing facility is included in the facility's rate or part of a regularly scheduled home health service for clients receiving home health services.
2. Clients who are residents of an Alternative Care Facility, as defined at Section 8.495.1, may receive Immunization services from their own physician. They may also receive Immunization services as part of a home health service in accordance with Section 8.815.4.C.1.

#### **8.815.5 Prior Authorization Requirements**

8.815.5.A. Prior authorization is not required for this benefit.

#### **8.815.6 Non-covered Services**

8.815.6.A. The following services are not covered by Colorado Medicaid:

1. For clients 18 years of age and younger, Vaccines that have been obtained from a source other than ~~VFC~~ the federal government;
2. Immunization and Vaccine Administration Services provided by a ~~S~~ school ~~d~~ District provider; and
3. Travel-related Immunization and Vaccine Administration Services.