DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Prescribing Providers, Section 8.590
Rule Number: MSB 22-12-02-A
Division / Contact / Phone: Health Policy / Russ Zigler / 303-866-5927

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 22-12-02-A, Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Prescribing Providers, Section 8.590

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) 8.509.1, 8.590.2.A, 8.590.2.S, 8.590.3.D, 8.590.3.F, 8.590.4.E, 8.590.7.N, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.590.1 with the proposed text beginning at 8.590.1.M through the end of 8.590.2.A.2. Replace the current text at 8.590.2.S through the end of 8.590.2.S.3.a. Replace the current text at 8.590.3.D with the proposed text beginning at 8.590.3.D through the end of 8.590.3.D.9. Replace the current text at 8.590.3.F with the proposed text beginning at 8.590.3.F through the end of 8.590.3.F. Replace the current text at 8.590.4.E with the proposed text beginning at 8.590.4.E through the end of 8.590.4.E. Replace the current text at 8.590.7.N with the proposed text beginning at 8.590.7.N through the end of 8.590.7.N.8. This rule is effective May 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Prescribing Providers, Section 8.590
Rule Number: MSB 22-12-02-A
Division / Contact / Phone: Health Policy / Russ Zigler / 303-866-5927

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 aligns the home health services rule with current Department policy and federal regulation at 42 CFR § 440.70, by adding physician assistants, nurse practitioners, and clinical nurse specialists to the list of providers authorized to order durable medical equipment. This rule revision allows such practitioners to order durable medical equipment.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR § 440.70(3)(b)(iii)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   CRS §§ 25.5-4-416; 25.5-5-202(1)(f), (y); 25.5-8-107(1)(a)(V)

Initial Review **03/10/23** Final Adoption **04/14/23**
Proposed Effective Date **05/30/23** Emergency Adoption

DOCUMENT #05

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Prescribing Providers, Section 8.590
Rule Number: MSB 22-12-02-A
Division / Contact / Phone: Health Policy / Russ Zigler / 303-866-5927

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.

   Clients receiving durable medical equipment (DME), and the providers of such equipment, are affected by the proposed rule. Both classes benefit from the proposed rule, which expands access to care by allowing a broader range of providers to order durable medical equipment.

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

   Allowing a broader range of providers to order and distribute DME provides clients more convenient access to DME.

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 addition of nurse practitioners, clinical nurse specialists, and physician assistants to the list of prescribing providers for DME does not result in any cost to the Department or any other agency. This rule change does not impact the number of clients approved or increase the amount of services approved because these new ordering practitioners would not be approving any additional services.

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 aligning Department rule with current Department policy. There are no known costs of the proposed rule. The cost of inaction is misalignment between Department rule and Department policy. There are no benefits to inaction.

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

There are no less costly methods or less intrusive methods for aligning Department rule with Department policy.

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 aligning Department rule with Department policy.

8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

8.590.1 DEFINITIONS

[SECTIONS 8.590.1.A-L REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

M. Licensed Practitioner means, for the purposes of Section 8.590, a physician, physician assistant, nurse practitioner, or clinical nurse specialist.

N. Medical Necessity, means for the purposes of Section 8.590, ~~means~~ the definition as described at ~~10 CCR 2505-10,~~ Section 8.076.1.8.

~~N~~O. Misuse means failure to maintain or the intentional utilization of DME and Supplies in a manner not prescribed, recommended or appropriate that results in the need for repairs or replacement. Misuse also means DME and Supplies used by someone other than the member for whom it was prescribed.

~~O~~P. Prosthetic or Orthotic Device means replacement, corrective or supportive devices that artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

~~P~~Q. Qualified Health Care Professional means a licensed physical therapist, a licensed occupational therapist, or other licensed health care professional who performs specialty evaluations within his/her scope of practice and who has no Financial Relationship with a Complex Rehabilitation Technology Supplier.

~~Q~~R. Related Owner means an individual with 5% or more ownership interest in a business and one entitled to a legal or equitable interest in any property of the business whether the interest is in the form of capital, stock, or profits of the business.

~~R~~S. Related Party means a provider who is associated or affiliated with, or has control of, or is controlled by the organization furnishing the DME and Supplies. An owner related individual shall be considered an individual who is a member of an owner's Immediate Family.

~~S~~T. Speech Generating Device (SGD) means a device that provides multiple methods of message formulation and is used to establish, develop or maintain the ability to communicate functional needs. These devices are electronic and computer based and can generate synthesized (computer-generated) or digitized (natural human) speech output for expressive communication.

~~T~~U. Start Of Service means the date that the ordering practitioner signs the written order for durable medical equipment following the face-to-face encounter with the member.

~~U~~V. Wheelchair means any wheelchair or scooter that is motor driven or manually operated for the purposes of mobility assistance, purchased by the Department or donated to the member.

~~V~~W. Wrongful Disposition means the mismanagement of DME and Supplies by a member by selling or giving away the item reimbursed by the Department.

8.590.2 BENEFITS

8.590.2.A. All covered DME and Supplies shall, at a minimum, be:

1. ~~A~~ Medical~~ly~~ ~~Necessity~~Necessary; and

2. Prescribed by a ~~physician and, when applicable, recommended by an appropriately licensed practitioner~~Licensed Practitioner.

3. At-home over-the-counter COVID-19 tests may be prescribed by a licensed pharmacist.

[SECTIONS 8.590.2.B-R REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

8.590.2.S. Rental Policy.

1. The Department may set a financial cap on certain rental items. The monetary price for those items shall be determined by the Department and noted in the fee schedule. The provider is responsible for all maintenance and repairs as described at Section 8.590.4.L~~N~~-P, until the cap is reached.

2. Upon reaching the capped amount, the equipment shall be considered purchased and shall become the property of the member. The provider shall give the member or caregiver all applicable information regarding the equipment. The equipment shall not be under warranty after the rental period ends.

3. The rental period may be interrupted~~,~~ for a maximum of sixty consecutive days.

   a. If the rental period is interrupted for a period greater than sixty consecutive days, the rental period must begin again. The interruption must be justified, documented by a ~~physician~~Licensed Practitioner, and maintained by the provider as described at ~~10 CCR 2505-10,~~ Section 8.590.4.E.7.

4. If the member changes providers, the current rental cap remains in force.

8.590.3 PRIOR AUTHORIZATION

[SECTIONS 8.590.3.A-C REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

8.590.3.D. Prior authorization requests shall~~,~~ include the following information:

1. A full description of the item(s).

2. The requested number of items.

3. A full description of all attachments, accessories and/or modifications needed to the basic item(s).

4. The effective date and estimated length of time the item(s) will be needed.

5. The medical diagnosis, prognosis for improvement or deterioration, ~~previous and~~ description of previous and current treatments and any other clinical information necessary to establish Medical Necessity for the member.

6. Descriptions of any specific physical limitations, or current functional needs~~,~~ the member may have that are relevant to the prior authorization consideration.

7. The member's prescribing ~~physician's~~Licensed Practitioner's, primary care physician's and provider's name and identification numbers.

8. The serial numbers for all Wheelchair repairs.

9. The prescribing ~~physician's~~ Licensed Practitioner's signature. The prescribing ~~physician~~ Licensed Practitioner ~~can~~ shall either sign the authorization or attach a written prescription or letter of Medical Necessity to the authorization.

[SECTIONS 8.590.3.E REMAINS UNCHANGED AND IS NOT AFFECTED BY THIS RULEMAKING]

8.590.3.F. Diagnostic and clinical information shall be completed prior to the ~~physician's~~ Licensed Practitioner's signature. The provider shall not complete or add information after the ~~physician~~ Licensed Practitioner has signed the document.

[SECTIONS 8.590.3.G-H REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

8.590.4 PROVIDER RESPONSIBILITIES

[SECTIONS 8.590.4.A-D REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

8.590.4.E. Providers shall maintain the following for all items provided to a member:

1. ~~Physician~~ Licensed Practitioner prescriptions.
2. Approved prior authorization requests.
3. Additional documentation received from physicians or other licensed practitioners.
4. Documentation that the member or caregiver ~~have~~ has been provided with the following:
    a. Manufacturer's instructions.
    b. Warranty information.
    c. Registration documents.
    d. Service manual.
    e. Operating guides.
5. Documentation ~~on~~ for all reimbursed equipment, which shall include:
    a. Manufacturer's name and address.
    b. Date acquired.
    c. Acquisition cost.
    d. Model number.
    e. Serial number.
    f. Accessories, attachments or special features included in the item.
6. Providers shall verify that equipment requiring repairs belongs to the presenting member.

7. Providers shall retain all documentation ~~for a period of six~~seven years.

8. Providers shall provide a copy of all documentation to a member or ~~his/her~~their representative, if requested.

[SECTIONS 8.590.4.F-Q REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

[SECTIONS 8.590.5-6 REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

8.590.7 REIMBURSEMENT

[SECTIONS 8.590.7.A-M REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

8.590.7.N. Face-to-Face Encounters

1. Compliance with this section is required as a condition of payment for DME requiring face-to-face encounters.

2. For DME specified in the Billing Manual, a face-to-face encounter must be performed related to the primary reason a member requires the DME.

~~2~~3. The face-to-face encounter must occur no more than six months before the DME is first provided to a member.

~~3~~4. The face-to-face encounter must be conducted by one of the following practitioners:

a. The ~~physician~~ Licensed Practitioner responsible for prescribing the DME;

b. A nurse practitioner or clinical nurse specialist, working in collaboration with the prescribing ~~physician~~Licensed Practitioner; or

c. A physician assistant under the supervision of the prescribing ~~physician~~Licensed Practitioner.

~~4~~5. A practitioner may conduct a face-to-face encounter via telehealth or telemedicine if those services are covered by the Medical Assistance Program.

~~5~~6. If a non-physician practitioner performs a face-to-face encounter they must communicate the clinical findings of the face-to-face encounter to the ~~physician~~ Licensed Practitioner responsible for prescribing the related DME. Those clinical findings must be incorporated into a written or electronic document included in the member's medical record.

~~6~~7. A ~~physician~~ Licensed Practitioner who prescribes DME requiring face-to-face encounters must document the following:

a. ~~The~~ That the face-to-face encounter was related to the primary reason the member required the prescribed DME;

b. The name of the practitioner who performed the face-to-face encounter;

c. The date of the face-to-face encounter; and

d. ~~The~~ That the face-to-face encounter occurred within the required timeframe.

~~7~~8. ~~Compliance with this section is required as a condition of payment for DME requiring face-to-face encounters.~~

[SECTIONS 8.590.7.O-P REMAIN UNCHANGED AND ARE NOT AFFECTED BY THIS RULEMAKING]

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960 Schedule A
Rule Number: MSB 23-01-26-A
Division / Contact / Phone: Special Financing Division / 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 23-01-26-A, Revision to the Colorado Dental Health Care Program for Low-Income Seniors Schedule A

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), Section 8.960

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.960 with the proposed text beginning at 8.960.A through the end of 8.960.C.6.b.5. Replace the current text in 8.960 Appendix A with the proposed text beginning at 8.960 Appendix A through the end of 8.960 Appendix A. This rule is effective May 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960 Schedule A
Rule Number: MSB 23-01-26-A
Division / Contact / Phone: Special Financing Division / 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).

   The Dental Advisory Committee recommended that D5225, maxillary partial denture-flexible base and D5226, mandibular partial denture-flexible base be added to Schedule A. The Department is making changes to the CDP Procedure Descriptions to match the American Dental Association and making changes to the Dental Procedure Guidelines. This rule change also adds lettering to the definitions section.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022); Section 25.5-3-404(4), C.R.S.

Initial Review **03/10/23** Final Adoption **04/14/23**
Proposed Effective Date **05/30/23** Emergency Adoption

DOCUMENT #06

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960 Schedule A
Rule Number: MSB 23-01-26-A
Division / Contact / Phone: Special Financing Division / 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.

   The addition of D5225 and D5226 will benefit program participants as they will have another option for dentures that are easier to insert and remove due to the flexibility of the denture material. There will be no costs for any classes.

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

   Seniors in the program who have dexterity issues will be able to insert and remove the flexible denture base easier than other denture bases.

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 will have no fiscal impact with this rule change. The funds for the Colorado Dental Health Care Program for Low-Income Seniors are appropriated, and this rule update will have no effect on the appropriation.

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

   There will be no costs to the Department and program participants will benefit from more flexible dentures. Inaction will result in difficulty for participants who do not have the dexterity to use their hands for metal or resin-based dentures and they will continue to have difficulties with denturesor not be able to utilize dentures at all.

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

   The Department does not foresee any fiscal impact as a result of this rule change and no less costly methods were considered.

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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 use of the new procedures.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.A1 Definitions

1. 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.

2. 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.

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

4. 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.

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

6. Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2020).

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

8. 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.

9. Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, 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.

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

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

12. 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.

13. 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).

14. 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.

15. 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.

16. 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.

17. Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2020).

18. 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.

19. 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.

20. 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).

21. 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.

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

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

24. 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.

25. 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.

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

27. 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:

    a. ~~1.~~ An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2020);

    b. ~~2.~~ A community-based organization or foundation;

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

    d. ~~4.~~ A local public health agency; or

e. ~~5.~~ A private dental practice.

28. 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.

29. 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.

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

31. Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2020).

8.960.~~2~~ B Legal Basis

8.960.B.1 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.C~~3~~ Request of Grant Proposals and Grant Award Procedures

8.960.C.1.~~3.A~~ Request for Grant Proposals

8.960.C.1.a 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.C.2~~3.B~~ Evaluation of Grant Proposals

8.960.C.2.a 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) ~~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) ~~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) ~~3.~~ Preference will be given to grant proposals that clearly demonstrate the applicant's ability to:

a) ~~a.~~ Outreach to and identify Eligible Seniors;

b) ~~b.~~ Collaborate with community-based organizations; and

c) ~~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.C~~3~~.3~~C~~ Grant Awards

8.960.C.3.a 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.C.4~~3.D~~ Qualified Grantee Responsibilities

8.960.C.4.a A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

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

2) ~~2.~~ Demonstrate collaboration with community-based organizations;

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

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

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

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

8) ~~8.~~ Submit an annual report as specified under section 8.960.3.F.

8.960.~~3.E~~C.5 Invoicing

8.960.C.5.a 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) ~~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) ~~2.~~ The Department will pay no more than the established Program Payment per procedure rendered, as listed in Appendix A.

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

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

8.960.~~3.F~~C.6 Annual Report

8.960.C.6.a 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.

8.960.C.6.b The annual report shall be completed in a format specified by the Department and shall include:

1) ~~1.~~ The number of Eligible Seniors served;

2) ~~2.~~ The types of Covered Dental Care Services provided;

3) ~~3.~~ An itemization of administrative expenditures;

4) ~~4.~~ The procedures and amounts billed to Medicare Advantage Plans for Eligible Seniors; and

5) ~~5.~~ Any other information deemed relevant by the Department.

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodic oral evaluation - established client	D0120	$46.00	$46.00	$0.00	Evaluation performed on a client of record to determine any changes in the client's dental and medical health status since a previous comprehensive or periodic evaluation. This ~~may~~ includes an oral cancer evaluation, ~~and~~ periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the client. Report additional diagnostic procedures separately. ~~evaluation, diagnosis, treatment planning.~~ Frequency: One time per 6 month period per client.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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. Frequency: Two of D0140 per year per grantee. Not reimbursable on the same date as D0120 or D0150. Dental hygienists may only provide for an established client of record.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive oral evaluation - new or established client	D0150	$81.00	$81.00	$0.00	Evaluation used by general dentist or a specialist when evaluating a client comprehensively. Applicable to new clients; established clients with significant health changes or other unusual circumstances; or established clients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, and an evaluation and recording of the client's dental and medical history and general health assessment. A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0180.
Comprehensive periodontal evaluation - new or established client	D0180	$88.00	$88.00	$0.00	Evaluation for clients presenting signs & symptoms of periodontal disease & clients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the client's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0150.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - ~~complete~~ comprehensive series of radiographic images	D0210	$125.00	$125.00	$0.00	Radiographic survey of whole mouth, ~~usually consisting of 14-22 periapical & posterior bitewing images~~ intended to display the crowns & roots of all teeth, periapical areas, interproximal areas and ~~of~~ alveolar bone including edentulous areas. Panoramic radiographic image & bitewing radiographic images taken on the same date of service shall not be billed as a D0210. Payment for additional periapical radiographs within 60 days of a full month series or a panoramic film is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per client. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 must be billed and reimbursed as D0210. Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.
Intraoral - periapical first radiographic image	D0220	$25.00	$25.00	$0.00	Six of D0220 per 12 months~~one (1) per day~~ per client. Report additional radiographs as D0230. Working and final endodontic treatment films are not covered. Any combination of D0220 through , ~~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.~~

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - periapical each additional radiographic image	D0230	$23.00	$23.00	$0.00	D0230 must be utilized for additional films taken beyond D0220. Working and final endodontic treatment films are included in the endo codes. Not covered if billed with D3310, D3320, or D3330. Any combination of D0220 through , ~~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 through , ~~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 - two radiographic images	D0272	$42.00	$42.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through , ~~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 through , ~~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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Bitewings - four radiographic images	D0274	$60.00	$60.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through , ~~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. Counts as an intraoral complete series. ~~This does not constitute a full mouth intraoral radiographic series.~~ Any combination of D0220 through , ~~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.
Panoramic radiographic image	D0330	$63.00	$63.00	$0.00	Frequency: 1 per 5 years per client. Cannot be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 years.

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

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.
Application of ~~Interim~~ caries arresting medicament ~~application~~ – per tooth	D1354	$5.71	$5.71	$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)~~.

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 Restorations (including polishing): Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).					
Amalgam - one surface, primary or permanent	D2140	$112.67	$102.67	$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	$141.20	$131.20	$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 - three surfaces, primary or permanent	D2160	$170.88	$160.88	$10.00	~~Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included.~~ Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Amalgam - four or more surfaces, primary or permanent	D2161	$204.96	$194.96	$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 Restorations – Direct: Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases, and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).					
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.
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~~Incisal angle to be defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Resin-based composite - one surface, posterior	D2391	$134.00	$124.00	$10.00	~~Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included~~ Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. 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.
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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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.
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.

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - full cast noble metal	D2792	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - titanium	D2794	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	$87.00	$77.00	$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	$89.00	$79.00	$10.00	Not allowed within 6 months of placement.
Core buildup, including any pins when required	D2950	$225.00	$200.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. Not payable on the same tooth and same day as D2951.
Pin retention per tooth	D2951	$50.00	$40.00	$10.00	Pins placed to aid in retention of restoration. Can only be used in combination with a multi-surface amalgam.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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.
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 (Including Treatment Plan, Clinical Procedures and Follow-Up Care) Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy; pulpectomy is part of 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.					
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	$566.40	$516.40	$50.00	Frequency: One D3310 per lifetime per client per tooth. ~~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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	$661.65	$611.65	$50.00	Frequency: One D3320 per lifetime per client per tooth. ~~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.
Endodontic therapy, molar tooth (excluding final restoration)	D3330	$786.31	$736.31	$50.00	Frequency: One D3330 per lifetime per client per tooth. ~~Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.~~ Teeth covered: 2, 3, 14, 15, 18, 19, 30, and 31.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	$177.00	$167.00	$10.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in others.~~D4341 and D1110 can be reported on same service date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 can only be charged once, not per quadrant; A diagnosis of periodontitis with clinical attachment loss (CAL) included. Diagnosis and classification of the periodontology case type must be in accordance with documentation as currently established by the American Academy of Periodontology. Current periodontal charting must be present in client chart documenting active periodontal disease.~~ Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting. ~~Documentation of other treatment provided at same time will be requested.~~ • Cannot be charged on same date as D4346.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	$128.00	$128.00	$0.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures inD4342 and D1110 can be reported on same service date when date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 can only be charged once, not per quadrant; A diagnosis of periodontitis with clinical attachment loss (CAL) included. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting.. Documentation of other treatment provided at same time will be requested. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	D4346	$102.00	$92.00	$10.00	The removal of plaque, calculus, and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures. Frequency: once in a lifetime. • Any follow-up and re-evaluation are included in the initial reimbursement. • Cannot be charged on the same date as D1110, D4341, D4342, or D4910.
Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	D4355	$94.02	$84.02	$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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal maintenance procedures	D4910	$136.00	$136.00	$0.00	Procedure following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It ~~D4341 or D4342. This procedure~~ includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. Frequency: • Up to four times per fiscal year per client. • Cannot be charged on the same date as D4346. • Cannot be charged within the first three months following active periodontal treatment.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - maxillary	D5110	$874.52	$794.52	$80.00	Reimbursement made upon delivery of a complete maxillary denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130 or D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. ~~Complete dentures are provided once adequate healing has taken place following extractions.~~ This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	$875.94	$795.94	$80.00	Reimbursement made upon delivery of a complete mandibular denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130, D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. ~~Complete dentures are provided once adequate healing has taken place following extractions.~~ This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – maxillary	D5130	$874.52	$794.52	$80.00	Reimbursement made upon delivery of an immediate maxillary denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5130 can be reimbursed only once per lifetime per client. Complete denture, D5110, may be considered 5 years after immediate denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – mandibular	D5140	$875.94	$795.94	$80.00	Reimbursement made upon delivery of an immediate mandibular denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5140 can be reimbursed only once per lifetime per client. Complete dentures, D5120, may be considered 5 years after immediate denture was reimbursed – documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213	$844.31	$784.31	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can also be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	$844.31	$784.31	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	D5221	$607.61	$547.61	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5221 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	D5222	$607.61	$547.61	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5222 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5223	$844.31	$784.31	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5223 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5224	$844.31	$784.31	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5224 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5225	$763.24	$703.24	$60.00	Reimbursement made upon delivery of a partial maxillary denture to the client. D5225 and D5226 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 flexible 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 flexible 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 maxillary per every three years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5226	$763.24	$703.24	$60.00	Reimbursement made upon delivery of a partial mandibular denture to the client. D5225 and D5226 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 flexible 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 flexible 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 three years - documentation that existing prosthesis cannot be made serviceable must be maintained.
Repair broken complete denture base, mandibular	D5511	$123.70	$113.70	$10.00	Repair broken complete mandibular denture base. Frequency: two of D5511 per 12 months per client.~~, mandibular~~
Repair broken complete denture base, maxillary	D5512	$123.70	$113.70	$10.00	Repair broken complete maxillary denture base. Frequency: two of D5512 per 12 months per client.~~, maxillary~~
Replace missing or broken teeth - complete denture (each tooth)	D5520	$92.91	$82.91	$10.00	Replacement/repair of missing or broken teeth. Teeth 1 – 32 and must report tooth number.
Repair resin partial denture base, mandibular	D5611	$95.00	$85.00	$10.00	Repair resin partial mandibular denture base. Frequency: two D5611 per 12 months per client.~~, mandibular~~

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Repair resin partial denture base, maxillary	D5612	$95.00	$85.00	$10.00	Repair resin partial maxillary denture base. Frequency: two D5612 per 12 months per client., ~~maxillary~~
Repair cast partial framework, mandibular	D5621	$121.29	$111.29	$10.00	Repair cast partial mandibular framework. Frequency: two D5621 per 12 months per client., ~~mandibular~~
Repair cast partial framework, maxillary	D5622	$121.29	$111.29	$10.00	Repair cast partial maxillary framework. Frequency: Two D5622 per 12 months per client., ~~maxillary~~
Repair or replace broken retentive/clasping materials – per tooth	D5630	$131.00	$121.00	$10.00	Repair of broken clasp on partial denture base – per tooth. Teeth 1 – 32, report tooth number(s).
Replace broken teeth-per tooth	D5640	$94.02	$84.02	$10.00	Repair/replacement of missing tooth. Teeth 1 – 32, report tooth number(s).
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. Teeth 1 – 32, report tooth number(s).
Add clasp to existing partial denture	D5660	$136.05	$126.05	$10.00	Adding clasp to partial denture base – per tooth. Documentation may be requested when charged on partial delivered in last 12 months. Teeth 1 – 32, report tooth number(s).
Rebase complete maxillary denture	D5710	$322.00	$297.00	$25.00	~~Rebasing the denture base material due to alveolar ridge resorption.~~ Frequency: one ~~(1)~~ time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Reline maxillary partial denture (chairside)	D5740	$175.82	$165.82	$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	$177.49	$167.49	$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.
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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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	$111.78	$101.78	$10.00	~~Routine r~~Removal of tooth structure, ~~including~~ minor smoothing of socket bone, and closure as necessary. Frequency: One D7140 per lifetime per client per tooth. Teeth 1 – 32. ~~Treatment notes must include documentation that an extraction was done per tooth.~~
Extraction, ~~Surgical removal of~~ erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$172.88	$162.88	$10.00	Includes related cutting of gingiva and ~~removal of~~ bone, removal ~~and/or sectioning~~ of ~~erupted~~ tooth structure, minor~~,~~ smoothing of socket bone and closure. ~~as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth.~~ Frequency: One of D7210 per lifetime per client per tooth. Teeth 1 - 32
Removal of impacted tooth-soft tissue	D7220	$207.25	$187.25	$20.00	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32. Frequency: One of D7220 per 1 lifetime per ~~patient~~client per tooth.
Removal of impacted tooth-partially bony	D7230	$255.53	$235.53	$20.00	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7230 per 1 lifetime per patient per tooth

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of impacted tooth-completely bony	D7240	$296.38	$276.38	$20.00	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7240 per 1 lifetime per patient per tooth.
Removal of impacted tooth-completely boney, with unusual surgical complications	D7241	$389.20	$369.20	$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. Frequency: One of D7241 per lifetime per patient per tooth.
~~Surgical r~~Removal of residual tooth roots (cutting procedure)	D7250	$182.30	$172.30	$10.00	Includes cutting of soft tissue and ~~removal of~~ bone, removal of ~~and/or sectioning of residual~~ tooth structure, ~~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. Teeth 1 – 32 Frequency: One D7250 per lifetime per patient per tooth.
Primary closure of a sinus perforation	D7261	$452.46	$442.46	$10.00	Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fisulous tract. Narrative of medical necessity may be required and if the sinus perforation was caused by a current grantee or provider of the program.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Incisional biopsy of oral tissue-soft	D7286	$381.00	$381.00	$0.00	For partial removal of an architecturally intact specimen only. D7286 is not used at the same time as codes for apicoectomy/periradicular curettage and does not entail an excision. ~~Removing tissue for histologic evaluation.~~ Treatment notes must include documentation and proof that biopsy was sent for evaluation.
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	$150.00	$140.00	$10.00	D7310 is distinct (separate procedure) from extractions. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One D7310 or D7311 per lifetime per patient per quadrant.~~Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone.~~ Reported per quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	$139.42	$129.42	$10.00	D7311 is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One D7311 or D7310 per lifetime per patient per quadrant.~~Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone.~~ Reported per quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	$200.47	$190.47	$10.00	No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant.~~Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities.~~ Reported per quadrant.
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	$200.47	$190.47	$10.00	No extractions performed in an edentulous area. See D7311 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant.~~Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities.~~ Reported per quadrant.
Removal of lateral exostosis (maxilla or mandible)	D7471	$290.11	$280.11	$10.00	Limited to the ~~R~~removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal.~~a benign bony outgrowth (bone spur) for proper prosthesis fabrication.~~ Reported per arch (LA or UA)~~.~~

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of torus palatinus	D7472	$341.08	$331.08	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal.~~To remove a malformation of bone for proper prosthesis fabrication~~ Must list quadrant.
Removal of torus mandibularis	D7473	$332.69	$322.69	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal.~~To remove a malformation of bone for proper prosthesis fabrication~~ Must list quadrant.
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins. One of D7510 per lifetime per client per tooth. Report per tooth.
Palliative ~~(emergency)~~ treatment of dental pain ~~-~~ per visit~~minor procedure~~	D9110	$78.23	$53.23	$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	$41.72	$41.72	$0.00	One of D9219 or D9310 per 12 month(s) per ~~provider or location~~grantee

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Deep sedation/general anesthesia-each 15 minute increment	D9223	$103.40	$93.40	$10.00	~~Ten~~ Nine of D9223 per 1 day per patient. Not allowed with D9243
Intravenous moderate (conscious) sedation/analgesia-first 15 minutes	D9239	$109.23	$99.23	$10.00	One of D9239 per 1 day per patient.
Intravenous moderate (conscious)sedation/analgesia-each 15 minute increment	D9243	$103.40	$93.40	$10.00	~~Fourteen~~ Thirteen of D9243 per 1 day per patient. Not allowed with D9223

EXPLANATION OF RESTORATIONS		
Location	Number of Surfaces	Characteristics
Anterior ~~-~~ **Mesial, Distal, Incisal, Lingual, or Facial (or Labial)**	1	Placed on one of the five ~~following five~~ surface classifications. ~~– Mesial, Distal, Incisal, Lingual, or Labial.~~.
	2	Placed, without interruption, on two of the ~~five~~ surface classifications ~~– e.g., Mesial-Lingual~~.
	3	Placed, without interruption, on three of the ~~five~~ surface classifications ~~– e.g., Lingual-Mesial-Labial~~.
	4 or more	Placed, without interruption, on four or more of the ~~five~~ surface classifications ~~– e.g., Mesial-Incisal-Lingual-Labial~~.
Posterior ~~–~~ **Mesial, Distal, Occlusal, Lingual, or Buccal**	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: Creation of the Medical Assistance Rule concerning the Secure Transport Benefit, Section 8.019
Rule Number: MSB 22-12-13-B
Division / Contact / Phone: Health Policy Office / Erica Schaler / 2573

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 22-12-13-B, Creation of the Medical Assistance Rule concerning the Secure Transport Benefit, Section 8.019

3. This action is an adoption of: new rules

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

   Sections(s) 10 CCR 2505-10 8.019, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text beginning at 8.019 through the end of 8.019. This rule is effective May 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Creation of the Medical Assistance Rule concerning the Secure Transport Benefit, Section 8.019
Rule Number: MSB 22-12-13-B
Division / Contact / Phone: Health Policy Office / Erica Schaler / 2573

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 creates a new Secure Transport benefit. Members will be eligible to utilize this benefit without a PAR so long as they are experiencing a behavioral health crisis and meet the criteria for medical necessity. Secure Transport is only available during a behavioral health crisis, therefore, this benefit is not available for a return trip and NEMT may have to be utilized in such cases.

   The new Secure Transportation benefit fulfills legislative mandates set forth HB 21-1085. The statewide service oversight falls under the authority of the Colorado Department of Public Health and Environment (CDPHE). Under CDPHE rule 6 CCR 1011-4, the amount, scope, and duration of the benefit are defined.

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:

   Federal authority for the Rule, if any:

   Title XIX of the Social Security Act Section 1905(a)(30)

   42 CFR 440.170

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   Section 25.5-5-328, C.R.S.

Initial Review	**03/10/23**	Final Adoption	**04/14/23**
Proposed Effective Date	**05/30/23**	Emergency Adoption	

DOCUMENT #07

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Title of Rule: Creation of the Medical Assistance Rule concerning the Secure Transport Benefit, Section 8.019
Rule Number: MSB 22-12-13-B
Division / Contact / Phone: Health Policy Office / Erica Schaler / 2573

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.

   Individuals experiencing a behavioral health crisis may benefit from this rule. These members will have the opportunity to for affordable and discrete transportation to a facility and receive treatment for the behavioral health crisis they are experiencing. Additionally, EMT providers will benefit as they will have fewer behavioral health patients to transport and will be able to focus primarily on medical emergencies. The classes who will bear the cost of secure transportation include providers, Colorado Medicaid, the counties who oversee licensure, the Behavioral Health Administration, and the Colorado Department of Public Health and the Environment.

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 quantitative impact of the proposed rule upon the community is anticipated to be positive. Individuals experiencing a behavioral health crisis will have access to secure transportation. This positive impact also spans into a qualitative one as providers will have training that better aligns with the needs of a behavioral health crisis.

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 cost to the Department for this benefit is minimal as CDPHE and the BHA are bearing the costs of dispatch and provider licensure. This benefit will likely have a positive effect on state revenues as the state will be spending less on emergency transportation and providers unfamiliar with behavioral health crises responding to these types of emergencies will be able to better serve medical emergent members. Emergency room costs will decrease as fewer members will utilize emergency rooms

for behavioral health emergencies and instead will have transportation to alternative settings designed to treat behavioral health patients.

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

   There will be costs associated with publicizing this rule and making affected parties aware of its implementation, along with the fiscal costs associated with the secure transportation program itself. The rule's main benefit will be the ability of secure transport providers to be reimbursed for their work by the state. Conversely, failing to act on this rule will likely prevent the Secure Transportation program from succeeding, denying patients experiencing a behavioral health crisis from receiving this type of transport.

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

   There is likely not a less-costly way to achieve the purpose of this rule because this rule is designed to authorize state payment for a benefit provided by federal funding, and is tailored so that the Department's rule meets federal requirements while complying with HB 21-1085

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.

   No alternatives were considered because this regulation is designed to qualify for federal funding for secure transportation and significant deviation from federal requirements would jeopardize the state's ability to meet those requirements.

8.019 SECURE TRANSPORTATION

8.019.A DEFINITIONS

1. "Behavioral Health" means an individual's mental and emotional well-being and actions that affect an individual's overall wellness. Behavioral health issues and disorders include substance use disorders, serious psychological distress, suicide, and other mental health disorders, and range from unhealthy stress or subclinical conditions to diagnosable and treatable diseases. The term "behavioral health" is also used to describe service systems that encompass prevention and promotion of emotional health and prevention and treatment services for mental health and substance use disorders.

2. "Behavioral Health Crisis" means a significant disruption in a person's mental or emotional stability or functioning resulting in an urgent need for immediate assessment and treatment to prevent a further or serious deterioration in the person's mental or physical health.

3. "Secure Transportation" or "Secure Transportation Services" means urgent transportation services provided to individuals experiencing a Behavioral Health Crisis as further defined at 6 C.C.R. 1011-4: 2.22.

8.019.B CLIENT ELIGIBILITY

1. A Colorado Medicaid member is eligible for Secure Transportation Services if the member is in a Behavioral Health Crisis. A Behavioral Health Crisis may be established by an intervening professional as defined in Section 27-65-102(20), C.R.S.; skilled professional as defined in 2 C.C.R. 502-1; independent professional person as defined in Section 27-65-102(19), C.R.S.; certified peace officer as defined in 4 C.C.R. 901-1, Rule 1(k), Section 21.400.1; or by an Emergency Medical Services (EMS) provider as defined in 6 C.C.R. 1015-3:1, 2.22.

8.019.C PROVIDER ELIGIBILITY

1. A Medicaid enrolled provider that is licensed and meets all requirements set forth at to 6 C.C.R. 1011-4 may provide secure transportation services.

8.019.D COVERED SERVICES

1. Secure Transportation includes:

    a. Transportation of an individual from the community to a facility for treatment and evaluation pursuant to Section 27-65-103 or 27-65-105(1), C.R.S. and Article 65 of Title 27;

    b. Transportation of an individual from any location to an approved treatment facility or to a walk-in crisis center that is in operation as part of the behavioral health crisis response system as described in Articles 81 and 82 of Title 27; Section 27-81-106, C.R.S.; or

    c. An individual who is receiving transportation across levels of care or to a higher or lower level of care, transportation between any of the following types of facilities:

        i. An emergency medical services facility;

        ii. A facility designated by the Executive Director of DHS for the treatment and evaluation pursuant to Article 65 of Title 27;

iii. An approved treatment facility, as described in Section 27-81-106, C.R.S.;

iv. A walk-in crisis center that is operating as part of the behavioral health crisis response system; or

v. A behavioral health entity (BHE) licensed with a current twenty-four (24) hour endorsement pursuant to Section 25-27.6-106, C.R.S.

8.019.E NON-COVERED SERVICES

1. Secure Transportation does not include transportation services provided by law enforcement;

   a. Except that any member of a co-responder team may provide Secure Transportation Services if that co-responder:

      i. Is not law enforcement or personnel employed by or contracted with a law enforcement agency; and

      ii. Holds a valid license for Secure Transportation by the county in which the Secure Transportation originates; and

      iii. Provides Secure Transportation in a vehicle:

         1) With a valid permit issued by the county in which the Secure Transportation originates; and

         2) That meets the minimum requirements for Secure Transportation services set forth at 6 CCR 1011-4.

8.019.F PRIOR AUTHORIZATION REQUIREMENTS

1. Prior authorization is not required.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act rule concerning the Hospital Back-Up Program Bed Cap, Section 8.470.7
Rule Number: MSB 23-02-27-A
Division / Contact / Phone: Office of Community Living / Richard Clark / 303-866-6518

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 23-02-27-A Emergency Revision to the Medical Assistance Act rule concerning the hospital back-up program bed cap

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):

   Section 8.470.7 Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.470.7.A.8 with the proposed text beginning at 8.470.7.A.8 through the end of 8.470.7.A.8. Replace the current text at 8.470.7.C with the proposed text beginning at 8.470.7.C through the end of 8.470.7.C. This rule is effective May 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act rule concerning the Hospital Back-Up Program Bed Cap, Section 8.470.7
Rule Number: MSB 23-02-27-A
Division / Contact / Phone: Office of Community Living / Richard Clark / 303-866-6518

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 Hospital Back-Up Program (HBU) provides hospital level of care in a skilled nursing facility for Medicaid members who no longer need acute care in a hospital but require 24-hour monitoring and life sustaining technology for complex medical conditions such as complex wounds, ventilator dependence. Not every skilled nursing facility operates an HBU and there are 5 HBU facilities in Colorado. Currently, the HBU rules limit the number of members a facility can serve in its HBU program at 25. This proposed rule change removes that fixed limit in order to allow the Department to determine on an individual facility basis how many members they are able to safely support. This gives the Department the flexibility to respond to changes in provider capacity to serve these individuals. The Department will make decisions on the number of members a facility may serve in HBU based upon safe staffing levels, recent survey outcomes, and financial stability. The Department will coordinate with the Colorado Department of Public Health and Environment on any decision for HBU bed capacity.

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:

Federal authority for the Rule, if any:

42 C.F.R. § 447.272

3. **State Authority for the Rule:**

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

Initial Review
Proposed Effective Date **05/30/23**
Final Adoption **04/14/23**
Emergency Adoption

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act rule concerning the Hospital Back-Up Program Bed Cap, Section 8.470.7
Rule Number: MSB 23-02-27-A
Division / Contact / Phone: Office of Community Living / Richard Clark / 303-866-6518

REGULATORY ANALYSIS

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

This is a cost neutral change that primarily affects the volume of service delivery in a single location. The rule change addresses the fact there is a declining number of providers, and in order to maintain access to care to the eligible population, more residents will need to be served in a single location.

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

There are currently 24 HBU members living at an HBU that is closing. Members who are ventilator dependent will primarily be served in 3 other HBU approved facilities. Overall, the number of HBU members in approved facilities will increase. The Department will work with and support these facilities with the transition and ensure that they are able to safely meet the member's needs.

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.

This is anticipated to be cost neutral. The demand for services remains the same, there are fewer providers serving the target population.

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

As stated in the response to question 3 above, the proposed rule is anticipated to be cost neutral. If the proposed rule is not approved, access to HBU level of care would be significantly limited. Members would either face re-hospitalization or moving away from their home community.

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

   Due to the level of specialized medical care that the HBU members require, there are not any less costly or less intrusive methods to achieve the purpose of this rule as a hospital is the only other qualified provider to meet their needs.

8. **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 main alternative to address the need is to build HBU provider capacity across the state. There is a time sensitive need for the Department to be able to expand the ability existing approved HBU to serve members. It takes time for facilities to meet specialized, clinical staffing requirements and building requirements such as increased generator capacity to support members using ventilators during emergencies. The Department is reviewing options to increase provider capacity and will continue to focus on this effort.

8.470 HOSPITAL BACK UP LEVEL OF CARE

8.470.7 NURSING FACILITY REQUIREMENTS FOR PARTICIPATION IN THE HBU PROGRAM

8.470.7.A In order to participate in the Hospital Back Up Program, the nursing facility shall submit a letter of intent to the Department that demonstrates the nursing facility:

1. Is Medicaid certified and licensed to provide skilled care;

2. is financially stable;

3. can provide skilled nursing facility services 24 hours a day;

4. Has staff stability;

5. Has a history of survey compliance;

6. Complies with the direct client care regulations administered by CDPHE as outlined in 6 CCR 1011-1 Chapter 2: General Licensure Standards and "Chapter 5: Nursing Care Facilities";

7. Has a recommendation from CDPHE for the nursing facility to participate in the hospital back up level of care program.

8. Has the desired number of beds available to be designated for the HBU Program~~, not to exceed 25 beds.~~.

8.470.7.B. The Department may request evidence of financial stability and survey compliance at any time during the nursing facility's participation.

8.470.7.C. The Department may limit the number of HBU beds at a nursing facility based on staffing, survey compliance and/or financial stability. Additionally, t~~T~~he Department may deny or revoke authorization of a nursing facility to participate as a hospital back up level of care facility if they do not meet the requirements outlined in section 8.470.7.A.

8.470.7.D. If the nursing facility has applied to admit clients who are ventilator dependent, the nursing facility shall also meet the following additional requirements:

1. Maintain clinical care staff trained in critical care and/or pulmonary medicine on the ventilator unit 24 hours a day, 7 days a week;

2. Have a back-up generator capable of providing heat, cooling and continuous electricity for needed equipment in the event of power outages; and

3. Maintain 24-hour on-site coverage by a respiratory therapist, who shall monitor any client weaning off of a ventilator and adjust ventilator settings as needed.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Co-payment, Section 8.754.1.H
Rule Number: MSB 23-02-27-B
Division / Contact / Phone: Health Policy / Russ Zigler / 303-866-5927

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 23-02-27-B, Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Co-payment, Section 8.754.1.H

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

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.754.1.H with the proposed text beginning at 8.754.1.H through the end of 8.754.1.H. This rule is effective May 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Co-payment, Section 8.754.1.H
Rule Number: MSB 23-02-27-B
Division / Contact / Phone: Health Policy / Russ Zigler / 303-866-5927

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).

   Proposed rule aligns the Department's inpatient hospital co-payment amount with federal regulation and the State Plan.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 447.52(b)(1)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

Initial Review
Proposed Effective Date **05/30/23**
Final Adoption **04/14/23**
Emergency Adoption

DOCUMENT #05

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Co-payment, Section 8.754.1.H
Rule Number: MSB 23-02-27-B
Division / Contact / Phone: Health Policy / Russ Zigler / 303-866-5927

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.

   Members admitted to inpatient hospitals are affected by the proposed rule. Such members benefit from a single, predictable copayment amount for inpatient hospital admission that is known prior to admission, rather than the previous copayment calculation of $10.00 per day up to 50% of the Medicaid rate for the first day of care in the hospital, which can only be calculated after discharge.

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

   Members benefit from a single, predictable copayment amount for inpatient hospital admission that is known prior to admission, rather than the previous copayment calculation of $10.00 per day up to 50% of the Medicaid rate for the first day of care in the hospital, which can only be calculated after discharge.

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 change to a $25 copayment per inpatient hospital admission is anticipated by the Department to be fiscally neutral.

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 $25 member copayment per inpatient hospital admission. The benefit of the proposed rule is alignment with federal regulation and current Department policy in the State Plan. The cost of inaction is misalignment between Department rule and federal regulations, and misalignment between Department rule and current Department policy in the State Plan.

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

There are no less costly methods or less intrusive methods for aligning Department rule with federal regulation and with current Department policy in the State Plan.

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 aligning Department rule with federal regulation and with current Department policy in the State Plan.

8.754 CLIENT CO-PAYMENT

8.754.1 CLIENT RESPONSIBILITY

Clients shall be responsible for the following co-payments:

[SECTIONS 8.754.1.A-G UNCHANGED AND UNAFFECTED BY THIS RULE CHANGE]

8.754.1.H. Inpatient hospital, $25.00 per admission~~10.00 per day up to 50% of the Medicaid rate for the first day of care in the hospital~~.

[SECTIONS 8.754.A.I-M UNCHANGED AND UNAFFECTED BY THIS RULE CHANGE]