DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Act Rule concerning Base Wage regarding certain Home and Community Based Services, Section 8.511
Rule Number: MSB 22-05-19-A
Division / Contact / Phone: Benefits & Services Division / Michele Craig / 5147

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 22-05-19-A, Revision to Medical Assistance Act Rule concerning Base Wage regarding certain Home and Community Based Services, Section 8.511

3. This action is an adoption of: July 1, 2022 Appendix K waiver amendment and Legislative appropriation authorized in House Bill 22-1329

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

   Sections(s) 8.511.2 and 8.511.3, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: July 1, 2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.511 with the proposed text beginning at 8.511.2 through the end of 8.511.2. Replace the current text at 8.511 with the proposed text beginning at 8.511.3 through the end of 8.511.3. This rule is effective July 1, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Act Rule concerning Base Wage regarding certain Home and Community Based Services, Section 8.511
Rule Number: MSB 22-05-19-A
Division / Contact / Phone: Benefits & Services Division / Michele Craig / 5147

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 revision adds additional services to the Department's base wage rules pertaining to certain Home and Community Based Services (HCBS). The rule is being revised to include Foster Care Home Group Home Habilitation services in the HCBS-Children's Habilitation Residential Program (CHRP) waiver.

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:

   There is a critical shortage of providers for CHRP Foster Care Homes and Group Homes, due in large part to the much lower reimbursement rate for these services as compared to the reimbursement for similar services in the HCBS-Persons with Developmental Disabilities (DD) waiver. This results in children and youth being unable to access out of home residential services that best meet their needs which limits options to staying in the family home putting themselves and/or others at risk, hospitalization, and/or out of state placement. With the timely flexibility under the Appendix K waiver and budgetary authority through House Bill 22-1329, the Department is able to increase the reimbursement rates quickly in order to address this critical shortage of providers.

3. Federal authority for the Rule, if any:

   Appendix K waiver amendment July 1, 2022

4. State Authority for the Rule: House Bill 22-1329

   Sections 25.5-1-903, C.R.S. (2018);
   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021)

Initial Review Final Adoption
Proposed Effective Date Emergency Adoption

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Act Rule concerning Base Wage regarding certain Home and Community Based Services, Section 8.511
Rule Number: MSB 22-05-19-A
Division / Contact / Phone: Benefits & Services Division / Michele Craig / 5147

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 proposed regulation will positively affect children and youth with intellectual and developmental disabilities and complex behavior support needs who are eligible for the CHRP waiver, as well as family of those children and youth. There is not cost of this rule to these children, youth, and families. The benefit to these children, youth, and families eligible is increased residential reimbursement to expand system capacity for residential services, providing more options for individuals to choose from to best meet their needs.

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

   Changes will improve member outcomes by increasing provider capacity, expanding choice in services and will decrease the use of high-cost services such has emergency departments and out of state placement.

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 costs to the Department have been accounted for in the budgetary process.

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

   Inaction will result in continued limited availability of residential providers for children and youth eligible for the CHRP waiver. Due to current limited capacity, children, youth, and their families often have few alternatives to access the residential services they need. This means children and youth must seek temporary options such as emergency departments or longer term out of state placements causing trauma and separating them from their families and communities.

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

The provider requirements in the proposed rule are in alignment with base wage increases for other Home and Community Based Services providers. The reporting method is the least intrusive method for the Department to be able to verify the requirements of the base wage increase are met by the providers. There are not less costly options, if the rates are not increased for these CHRP residential services, few providers are able to offer the service resulting in continued limited capacity.

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 were no other options considered by the Department as this rule aligns reimbursement for residential services as well as requirements for base wage rate increases with other Home and Community Based Services.

8.511 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

8.511.1 DEFINITIONS

Definitions below only apply to Section 8.511.

A. Base Wage means the minimum hourly rate of pay of a Direct Care Worker for the provision of Home and Community-Based Services (HCBS). For the purposes of this rule, the base wage shall be $15.00 effective January 1, 2022.

B. Department means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

C. Direct Care Worker means a non-administrative employee or independent contractor of a Provider Agency or Participant Directed Program Employer of Record who provides hands-on care, services, and support to older adults and individuals with disabilities across the long-term services and supports continuum within home and community-based settings.

D. Minimum Wage means the rate of pay established in accordance with Section 15 of Article XVIII of the State Constitution and any other minimum wage established by federal or local laws or regulations. In addition to state wage requirements, federal or local laws or regulations may apply minimum, overtime, or other wage requirements to some or all Colorado employers and employees. If an employee is covered by multiple minimum or overtime wage requirements, the requirement providing a higher wage, or otherwise setting a higher standard, shall apply.

E. Plan of Correction means a formal, written response from a provider agency to the Department on identified areas of non-compliance with requirements listed in Section 8.511.4.

F. Participant Directed Program means a service model that provides participants who are eligible for Home and Community-Based Services the ability to manage their own in-home care, or have care managed by an authorized representative, provided by a direct care worker. Participant Directed Program participants, or their authorized representative, operate as Employers of Record with an established FEIN.

G. Provider means any person, public or private institution, agency, or business enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods. Pursuant to this rule, a provider that renders qualifying service(s) accepts responsibility to ensure qualifying Direct Care Workers currently under their employment are paid, at a minimum, the base wage.

H. Per Diem wage means daily rate of pay for Direct Care Workers for the provision of Home and Community-Based Services (HCBS). For purposes of this rule, the per diem wage shall apply to Direct Care Workers of residential service providers.

8.511.2 QUALIFYING SERVICES

A. Effective January 1, 2022, the Department will increase reimbursement rates for select Home and Community-Based Services. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher. Services requiring Direct Care Workers to be paid at least the base wage are as follows:

1. Adult Day Services

2. Alternative Care Facility (ACF)

3. Community Connector

4. Consumer Directed Attendant Support Services (CDASS)

5. Group Residential Support Services (GRSS)

6. Homemaker

7. Homemaker Enhanced

8. In-Home Support Services (IHSS)

9. Individual Residential Support Services (IRSS)

10. Job Coaching

11. Job Development

12. Mentorship

13. Personal Care

14. Prevocational Services

15. Respite

16. Specialized Habilitation

17. Supported Community Connections

18. Supported Living Program

B. In the event that a Direct Care Worker, based on state or local minimum wage laws, is eligible for a minimum wage that exceeds the base wage requirement, the Provider is required to compensate at the higher wage.

C. In the event that a Direct Care Worker is eligible for a per diem wage, the Provider is required to increase the Direct Care Worker's per diem wage effective January 1, 2022 by the percent of the Department's January 1, 2022 reimbursement rate increase.

D. Effective July 1, 2022, the Department will increase reimbursement rates for Foster Care Home, Host Home, and Group Home Habilitation service in the Home and Community Based Services-Children's Habilitation Residential Program (CHRP) waiver. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher.

1. In the event that a Direct Care Worker is eligible for a per diem wage, the Provider is required to increase the Direct Care Worker's per diem wage effective July 1, 2022 by the percent of the Department's July 1, 2022 reimbursement rate increase.

8.511.3 PROVIDER RESPONSIBILITIES

A. The Provider must ensure that contact information on file with the Department is accurate; information shall be utilized by the Department to complete oversight responsibilities per Section 8.511.4.

B. Providers shall notify Direct Care Workers who are affected by the base wage requirement each fiscal year up to and including Fiscal Year 2023-2024.

1. Provider shall utilize the Department provided letter.

C. Providers shall publish and make readily available the Department's designated contact for Direct Care Workers to submit questions, concerns or complaints regarding the base wage requirement.

D. On or before June 30, 2022 and June 30, 2023, providers shall attest to the Department that all Direct Care Workers receive at a minimum the required base wage or per diem wage increase.

1. Providers with Direct Care Workers eligible for the base wage must attest that the base wage has been applied. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after January 1, 2022.

d. Direct Care Workers' hourly base wage as of November 1, 2021 and current hourly base wage.

e. Current service(s) provided by each employee.

2. IRSS Providers and/or Providers with Direct Care Workers earning a per diem wage must attest to the per diem wage increase. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after January 1, 2022.

d. Direct Care Workers' per diem wage as of December 1, 2021 and per diem wage as of January 1, 2022.

3. CDASS Authorized Representatives/Employers of Record are exempt from attestation requirements.

E. For CHRP Habilitation Foster Care Home, Host Home, and Group providers, on or before June 30, 2023, providers shall attest to the Department that all Direct Care Workers receive at a minimum the required base wage or per diem wage increase.

1. Providers with Direct Care Workers eligible for the base wage must attest that the base wage has been applied. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after July 1, 2022.

d. Direct Care Workers' hourly base wage as of May 1, 2022 and current hourly base wage.

e. Current service(s) provided by each employee.

2. Providers with Direct Care Workers earning a per diem wage must attest to the per diem wage increase. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after July 1, 2022.

d. Direct Care Workers' per diem wage as of June 1, 2022 and per diem wage as of July 1, 2022.

F. Providers shall keep true and accurate records to support and demonstrate that all Direct Care Workers who performed the listed services within Section 8.511 received at a minimum the base wage or a per diem wage increase.

G~~F~~. Records shall be retained for no less than six (6) years and shall be made available for inspection by the Department upon request. Records may include, but are not limited to:

1. Payroll summaries and details

2. Timesheets

3. Paid time off records

4. Cancelled checks (front and back)

5. Direct deposit confirmations

6. Independent contractor documents or agreements

7. Per diem wage documents

8. Accounting records such as: accounts receivable and accounts payable

8.511.4 REPORTING & AUDITING REQUIREMENTS

A. The Department has ongoing discretion to request information from providers to demonstrate that all Direct Care Workers received the wage (base or per diem) increase. All records related to the base wage requirement received by the Provider for the services listed in Section 8.511.2 shall be made available to the Department upon request, within specified deadlines.

B. Providers shall respond to the Department's request for records to demonstrate compliance within the timelines and format specified by the Department.

C. Failure to provide adequate documents and timely responses may result in the Provider being required to submit a plan of correction and/or recoupment of funds.

D. If a plan of correction is requested by the Department, the Provider shall have forty-five (45) business days from the date of the request to respond. The Provider must notify the Department in writing within five (5) business days of receipt of the request if they will not be able to meet the deadline. The Provider must explain the rationale for the delay and the Department may or may not grant an extension in writing.

E. Upon the Department's receipt of the plan of correction, the Department will accept, request modifications, or reject the proposed plan of correction. Modifications or rejections will be accompanied by a written explanation. If a plan of correction is rejected, the Provider must resubmit a new plan of correction along with any requested documentation to the Department for review within five (5) business days of notification.

F. The Department may recoup part or all of the funding resulting from the base wage increase if the Department determines the Provider is not in compliance with Section 8.511.

G. If such determination is made to recoup funds, the Provider will be notified by the Department. All recoupments will be conducted pursuant to C.R.S. Section 25.5-4-301 and 10 C.C.R. 2505-10, Section 8.050.6, Informal Reconsideration and Appeals of Overpayments Resulting from Review or Audit Findings.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Emergency Department Services Cost Sharing, Section 8.754.2
Rule Number: MSB 22-05-31-B
Division / Contact / Phone: Health Programs Office / 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 22-05-31-B, Revision to the Medical Assistance Act Rule concerning Non-Emergent Emergency Department Services Cost Sharing, Section 8.754.2

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

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 7/1/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.754.2 with the proposed text beginning at 8.754.2 through the end of 8.754.2. This rule is effective July 1, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Emergency Department Services Cost Sharing, Section 8.754.2
Rule Number: MSB 22-05-31-B
Division / Contact / Phone: Health Programs Office / 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).

   The 2022 Colorado General Assembly Long Bill, House Bill 22-1329, increases the co-payment for non-emergent use of emergency department services from $6 to $8, effective July 1, 2022. This revision aligns Department rule with the increased co-payment amount.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   This rule is being brought as an emergency rulemaking to the June Medical Services Board meeting to align with House Bill 22-1329 and preserve the July 1, 2022 effective date.

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. (2021);
   Colorado House Bill 22-1329

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Emergency Department Services Cost Sharing, Section 8.754.2
Rule Number: MSB 22-05-31-B
Division / Contact / Phone: Health Programs Office / 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 receiving non-emergent services in an emergency room/department are affected by this rule and will bear the cost of the $8 co-payment.

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

   Members receiving non-emergent services in an emergency room/department will pay an additional $2 in co-payment.

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

   The Department anticipates that it will save $29,368 annually by increasing the member copayments from $6 to $8.

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

   The costs of the proposed rule are an additional $2 co-payment for members receiving non-emergent services in a emergency room/department. The benefits of the proposed rule aligning Department rule with House Bill 22-1329. The cost of inaction is misalignment between Department rule and House Bill 22-1329. There are no benefits of 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 to align Department rule with House Bill 22-1329.

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

DO NOT PUBLISH THIS PAGE

There are no alternative methods for aligning Department rule with House Bill 22-1329.

8.754 CLIENT CO-PAYMENT

8.754.2 NON-EMERGENCY SERVICES

Effective July 1, 2022, ~~N~~non-emergency services rendered in the hospital outpatient emergency room are subject to a $~~6~~8.00 co-payment, in compliance with 42 U.S.C. 1396o (2021), per visit.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Invasive Prenatal Testing, Section 8.732.4.E
Rule Number: MSB 22-05-31-A
Division / Contact / Phone: Health Programs Office / 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 22-05-31-A, Revision to the Medical Assistance Act Rule concerning Non-Invasive Prenatal Testing, Section 8.732.4.E

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

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 7/1/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.732.4.E with the proposed text beginning at 8.732.4.E through the end of 8.732.4.E. This rule is effective July 1, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Invasive Prenatal Testing, Section 8.732.4.E
Rule Number: MSB 22-05-31-A
Division / Contact / Phone: Health Programs Office / 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).

   The 2022 Colorado General Assembly Long Bill, House Bill 22-1329, covers non-invasive prenatal testing (NIPT) based on national standard guidelines, as developed by the American College of Obstetricians and Gynecologist (ACOG). This revision aligns Department rule concerning NIPT coverage with national standard guidelines.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   The rule is being brought as an emergency rule to the June 10, 2022 Medical Services Board meeting to preserve the July 1, 2022 effective date.

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. (2021);
   Colorado House Bill 22-1329

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Invasive Prenatal Testing, Section 8.732.4.E
Rule Number: MSB 22-05-31-A
Division / Contact / Phone: Health Programs Office / 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 receiving non-invasive prenatal testing (NIPT), and members rendering NIPT, are affected by this rule.

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

   Members will receive NIPT in accordance national standard guidelines.

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 probable costs of this rule change is that more members will utilize NIPT, which will increase Medicaid expenditures for the benefit. The General Assembly appropriated $1,044,059 to expand the benefit as part of House Bill 22-1329.

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

   The costs of the rule are provided in the answer to question 3. The benefits of the proposed rule are aligning Department rule with Colorado House Bill 22-1329. The cost of inaction is misalignment between Department rule and House Bill 22-1329. There are no benefits of 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 to align Department rule with House Bill 22-1329.

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

DO NOT PUBLISH THIS PAGE

There are no alternative methods for aligning Department rule with House Bill 22-1329.

8.732. MATERNITY SERVICES

8.732.4. COVERED SERVICES

8.732.4.E. Effective July 1, 2022, Genetic Screening, including but not limited to Non-Invasive Prenatal Testing (NIPT), and Genetic Counseling are covered in accordance with nationally recognized standards of care. Screening coverage is available for women carrying a singleton gestation who meet national standard guidelines.~~one or more of the following conditions:~~

~~1. Maternal age 35 years or older at delivery;~~

~~2. Fetal ultrasonographic findings indicated an increased risk of aneuploidy;~~

~~3. History of a prior pregnancy with a trisomy;~~

~~4. Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen; or~~

~~5. Parental balanced Robertsonian translocation with increased risk of fetal trisomy 13 or 21.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Special Financing Division Colorado Dental Health Care Program for Low-Income Seniors and Old Age Pension Concerning SB21-199, Section 8.900
Rule Number: MSB 22-05-27-A
Division / Contact / Phone:Special Financing / Chandra Vital / 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 22-05-27-A, Revision to the Special Financing Division Colorado Dental

3. This action is an adoption of: an amendment

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

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

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 7/1/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.940 with the proposed text beginning at 8.943 through the end of 8.943.
Replace the current text at 8.960 with the proposed text beginning at 8.960.1 through the end of 8.960.1.
This rule is effective July 1, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Special Financing Division Colorado Dental Health Care Program for Low-Income Seniors and Old Age Pension Concerning SB21-199, Section 8.900
Rule Number: MSB 22-05-27-A
Division / Contact / Phone:Special Financing / Chandra Vital / 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).

   Senate Bill 21-199 passed June 25, 2021 and removes the requirement to prove lawful presence in the US for state or local public benefits. This rule change is removing the lawful presence requirement from the Colorado Dental Health Care Program for Low-Income Seniors and the Old Age Pension Health Care Program.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   Senate Bill 21-199, effective July 1, 2022, removes the requirement to prove lawful presence in the US for state or local public benefits.

3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   25.5-2-101, C.R.S. (2021)
   25.5-3-404(4), C.R.S. (2021)

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Special Financing Division Colorado Dental Health Care Program for Low-Income Seniors and Old Age Pension Concerning SB21-199, Section 8.900
Rule Number: MSB 22-05-27-A
Division / Contact / Phone:Special Financing / Chandra Vital / 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.

   This will benefit all low-income aging individuals that were not able to participate in the Colorado Dental Health Care Program for Low-Income Seniors and the Old Age Pension Health Care Program due to not being able to prove lawful presence in the U.S. There will be no incurred 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.

   This rule update will allow the low-income aging population, that cannot prove lawful presence in the U.S. the ability to obtain services through the Colorado Dental Health Care Program for Low-Income Seniors and the Old Age Pension Health Care Program.

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

   The Department will have no fiscal impact with this rule change. The funds for the Colorado Dental Health Care Program for Low-Income Seniors and the Old Age Pension Health Care Program 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.

   This rule change is required due to the passing of Senate Bill 21-199.

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 on this rule change and there are not any less costly methods that were considered.

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.

   Updating these rules is the only method available to ensure compliance with Senate Bill 21-199.

8.940 OLD AGE PENSION HEALTH CARE PROGRAM

8.941 EXTENT AND LIMITATIONS OF MEDICAL CARE

8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM

In accordance with the Constitution of Colorado, Article XXIV, Section 7, and the Colorado Public Assistance Act, an Old Age Pension Health Care Program is established to provide necessary medical care for the Old Age Pension (OAP) recipients who do not qualify for Medicaid under Title XIX of the Social Security Act and Colorado statutes. The State Department is designated as the single State agency to administer the program.

A. The Old Age Pension Health Care Program provides optional benefits to clients who qualify for (State only) OAP pensions who do not qualify for Federal Financial Participation (FFP) in the Colorado Medicaid Program. These cases are coded with Supplemental Income Status Code (SISC) C.

B. Under the Old Age Pension Health Care Program, only the following State funded benefits are provided:

1. Physician and practitioner services

2. Inpatient hospital

3. Outpatient services

4. Lab and x-ray

5. Emergency transportation

6. Emergency services

7. Dental

8. Pharmacy

    i. Medicare Part D prescription drugs provided pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (defined at 42 U.S.C. sections 1395w-102 and 141 and 42 C.F.R. Part 423, et seq.) are not a benefit for those individuals who are eligible for both Medicare and the Old Age Pension Health Care Program. The pharmacy drug benefit under the Old Age Pension Health Care Program is subject to the requirements set forth at s Section 8.800.

9. Home health services and supplies

10. Medicare cost sharing

    i. If Medicare pays for a medical service that is a non-benefit under the Old Age Pension Health Care Program, the co-insurance and deductible will not be paid by the Old Age Pension Health Care Program.

C. For the benefits listed above, the Old Age Pension Health Care Program shall only be used to provide clients with health care services determined to be medically necessary by a qualified health care provider.

D. All other medical benefits not listed in paragraph B are excluded under the Old Age Pension Health Care Program. Inpatient care in an institution for tuberculosis or mental diseases, skilled and intermediate nursing facility services, and home and community-based services are also excluded.

E. Eligibility shall not be retroactive and shall begin on the date of application or date eligibility is established, whichever is later.

F. Counties shall provide information to Old Age Pension Health Care Program clients regarding the disposal of excess resources in order to qualify for the Medicaid program. Such information shall include advisements concerning the prohibition of transfer of assets without fair consideration.

8.941.2 DEFINITIONS

A. Aid to the Needy Disabled-Colorado Supplement (AND-CS) – Program that provides a supplemental payment for individuals age zero (0) to fifty-nine (59) who are receiving Social Security Income (SSI) due to a disability or blindness, but are not receiving the full SSI benefit standard, as defined in 9 CCR 2503-5 3.510.

B. Aid to the Needy Disabled-State Only (AND-SO) – Program that provides interim assistance to individuals age eighteen (18) through fifty-nine (59) years of age (unless diagnosed with blindness, then age zero [0] through fifty-nine [59] years of age) who are disabled or blind but have not been approved for SSI or Social Security Disability Insurance (SSDI). Individuals are required to meet the total disability requirements of the program in addition to the non-financial and financial eligibility requirements. Individuals who are partially disabled or have a short-term disability are not eligible.

C. Federal Financial Participation (FFP) – The portion paid by the federal government to states for their share of expenditures for providing Medicaid services and for administering the Medicaid program and certain other human services programs.

D. Medical ID Card – The card issued to members and used by providers to verify member eligibility.

E. Old Age Pension (OAP) – Program that provides financial assistance for low-income Colorado residents who are sixty (60) years of age or older who meet all financial and non-financial eligibility requirements.

F. Old Age Pension-C (OAP-C) – Program for individuals who are sixty (60) years of age or older who have been committed to the Colorado Mental Health Institute or to a Regional Center by order of the district or probate court.

G. State Department or Department – The Colorado Department of Health Care Policy and Financing.

H. Supplemental Income Status Code (SISC) – System codes used to distinguish the different types of state supplementary benefits (such as OAP) a recipient may receive. Supplemental Income Status Codes determine the FFP for benefits paid on behalf of groups covered under the Medical Assistance program.

I. Supplemental Security Income (SSI) – A Federal income supplement program funded by general tax revenues (not Social Security taxes) that provides income to aged, blind, or disabled individuals with little or no income and resources.

8.941.3 GROUPS ASSISTED UNDER THE OLD AGE PENSION HEALTH CARE PROGRAM

Old Age Pension Health Care Program benefits are provided to persons receiving OAP who do not meet SSI eligibility criteria but do meet the State eligibility criteria for the Old Age Pension Health Care Program. These persons qualify for a SISC C..

A. SISC C – this code is for persons eligible to receive financial assistance under OAP who do not receive an SSI payment, and do not otherwise qualify for the Colorado Medicaid Program. SISC C signifies that no FFP is available in medical assistance program expenditures.

B. Recipients of financial assistance under AND-CS, AND-SO, or OAP-C are not eligible for assistance under the Old Age Pension Health Care Program.

8.941.4 FINANCIAL ASSISTANCE

All rules applicable to Old Age Pension financial assistance program payments (as set forth in the Department of Human Services rules at 9 CCR 2503-5) shall apply to the Old Age Pension Health Care Program.

8.941.5 CERTIFICATION OF PAYMENT FOR PROVIDERS

When submitting a claim for medical services to the Old Age Pension Health Care Program providers must submit a certification that states the following: “I will accept as payment in full, payment made under the Old Age Pension Health Care Program, and certify that no supplemental charges have been, or will be, billed to the patient, except for those non-covered items, or services, if any, which are not reimbursable under the Old Age Pension Health Care Program.”

8.941.6 OUT-OF-STATE MEDICAL CARE

All requirements for out-of-state medical care as defined by Section 8.013 apply to the Old Age Pension Health Care Program for covered services with the exception that any reduction, suspension or elimination of benefits must be applied.

8.941.7 SUBMISSION OF CLAIMS

Rules governing the submission or payment of claims, provider or recipient appeals, third party liability, overpayment, fraud and abuse, and State identification numbers as defined in Section 8.100, apply to the Old Age Pension Health Care Program for covered services with the exception that any reduction, suspension or elimination of benefits provided must also be applied.

8.941.8 REIMBURSEMENT TO PROVIDERS

~~I.~~ When reimbursement rates are modified, notifications shall be published on the Department’s website and will be published in the Provider Bulletin.

8.941.9 CLIENT CO-PAYMENT

Clients are responsible for paying directly to providers a co-payment according to the regulations and fee schedule as set forth under Section 8.754.1.

Clients whose co-payments reach a limit of $300 within a January 1 through December 31 calendar year will be exempted from further co-payments during that year. The exemption will begin on the date of payment that the $300 limit cumulative maximum has been reached.

A client must present the Medical ID Card to the provider at the time a service is rendered in order to claim exemption from copayment for that service.

8.942 CHANGE OF SUPPLEMENTAL INCOME STATUS CODE (SISC) TO MEDICAID

8.942.1 MEDICAID QUALIFICATION

When a recipient of the Old Age Pension Health Care Program subsequently qualifies for Medicaid, their SISC must be changed to indicate Medicaid benefits. Additionally, the county must backdate the Medicaid benefits to the date the individual became eligible for Medicaid even if the recipient was eligible for the Old Age Pension Health Care Program at the time.

~~**8.943 IDENTIFICATION AND AFFIDAVIT REQUIREMENTS**~~

~~**8.943.1 Lawful Presence Documentation**~~

~~A. Each applicant eighteen (18) years of age or older, shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective September 17, 2020), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to Section 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.~~

~~B. If an applicant does not have the required documentation, he or she must be given a reasonable opportunity period of up to ten (10) business days to provide the required documentation. If the applicant does not provide the required documentation within those ten (10) business days, then the application shall be denied.~~

~~C. If an applicant whose benefits are terminated on the basis of not having the documents required by this section provides such documentation within ten (10) weeks of the date of denial, the denial shall be rescinded, and the client made eligible back to the data of application, provided he or she meet all other eligibility requirements.~~

~~**8.943.2 Each applicant eighteen (18) years of age or older shall execute an affidavit stating:**~~

~~A. That he or she is a United States Citizen or legal permanent resident; OR~~

~~B. That he or she is a legal permanent resident or otherwise lawfully present in the United States pursuant to 1 CCR 204-30 Rule 5.~~

~~**8.943.3 For an applicant who has executed an affidavit stating that he or she is an alien lawfully present in the United States under 8.943.2.B, the following shall apply:**~~

~~A. Verification of lawful presence shall be made through the Federal Systematic Alien Verification for Entitlements (SAVE) Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security.~~

B. The county or medical assistance site shall perform the verification of lawful presence no more than three business days after receipt of the affidavit stating that the applicant is otherwise lawfully present in the United States pursuant to 1 CCR 204-30 Rule 5. A SAVE verification is not needed for Applicants who provide an ID issued by a REAL ID Act compliant state that bears the REAL ID Act indicator.

8.943.4 Photocopies of the identification listed in 8.943.1 shall be acceptable identification.

A. The county shall retain a photocopy of the documentation required under section 8.943.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.1 Definitions

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

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

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

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

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

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

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

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

Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is able to demonstrate lawful presence in the country, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior or client is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans. An Eligible Senior shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective August 30, 2016), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 excludes later amendments to, or editions of, the referenced

~~material. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.~~

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

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

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

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

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

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

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

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

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

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

Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (2020).

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

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

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

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

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

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

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

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

2. A community-based organization or foundation;

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

4. A local public health agency; or

5. A private dental practice.

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

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

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

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

8.960.2 Legal Basis

The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S. (2020).

8.960.3 Request of Grant Proposals and Grant Award Procedures

8.960.3.A Request for Grant Proposals

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

8.960.3.B Evaluation of Grant Proposals

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

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

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

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

    a. Outreach to and identify Eligible Seniors;

    b. Collaborate with community-based organizations; and

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

4. The review panel shall consider the distribution of funds across the state in recommending grant proposals for awards. The distribution of funds should be based on the estimated percentage of Eligible Seniors in the state by Area Agency on Aging region as provided by the Department.

8.960.3.C Grant Awards

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

8.960.3.D Qualified Grantee Responsibilities

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

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

2. Demonstrate collaboration with community-based organizations;

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

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

5. For Eligible Seniors with dental coverage through a Medicare Advantage Plan, bill the Medicare Advantage Plan for dental procedures covered by the Medicare Advantage Plan prior to seeking payment from the Department. The Colorado Dental Health Care Program is secondary to the Medicare Advantage Plan dental coverage;

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

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

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

8.960.3.E Invoicing

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

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

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

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

4. Qualified Grantees shall not bill the Department for any procedures covered by Medicare Advantage Plans that have been billed and paid by the Medicare Advantage Plans;

5. Qualified Grantees shall indicate on the invoice if the Eligible Senior has dental coverage through a Medicare Advantage Plan and any claim to the Medicare Advantage Plan was adjudicated prior to billing the Department;

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

8.960.3.F Annual Report

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

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

1. The number of Eligible Seniors served;

2. The types of Covered Dental Care Services provided;

3. An itemization of administrative expenditures;

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

5. Any other information deemed relevant by the Department.

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

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

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - complete series of radiographic images	D0210	$125.00	$125.00	$0.00	Radiographic survey of whole mouth, usually consisting of 14-22 periapical & posterior bitewing images intended to display the crowns & roots of all teeth, periapical areas of alveolar bone. Panoramic radiographic image & bitewing radiographic images taken on the same date of service shall not be billed as a D0210. Payment for additional periapical radiographs within 60 days of a full month series or a panoramic film is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per client. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 must be billed and reimbursed as D0210. Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.
Intraoral - periapical first radiographic image	D0220	$25.00	$25.00	$0.00	D0220 one (1) per day per client. Report additional radiographs as D0230. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.

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. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.
Bitewing - single radiographic image	D0270	$26.00	$26.00	$0.00	Frequency: 1 in a 12 month period. Report more than 1 radiographic image as: D0272 two (2); D0273 three (3); D0274 four (4). Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - two radiographic images	D0272	$42.00	$42.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - three radiographic images	D0273	$52.00	$52.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

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, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Vertical bitewings – seven to eight radiographic images	D0277	$68.32	$68.32	$0.00	Frequency: 1 time in a 12-month period. This does not constitute a full mouth intraoral radiographic series. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
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.
Interim caries arresting medicament application – per tooth	D1354	$5.60	$5.60	$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 - 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.
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.

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

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

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

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	$566.40	$516.40	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 6-11 and 22-27.
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	$661.65	$611.65	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 4, 5, 12, 13, 20, 21, 28, and 29.
Endodontic therapy, molar tooth (excluding final restoration)	D3330	$786.31	$736.31	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 2, 3, 14, 15, 18, 19, 30, and 31.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	$177.00	$167.00	$10.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. D4341 and D1110 can be reported on same service date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 can only be charged once, not per quadrant; A diagnosis of periodontitis with clinical attachment loss (CAL) included. Diagnosis and classification of the periodontology case type must be in accordance with documentation as currently established by the American Academy of Periodontology. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting. Documentation of other treatment provided at same time will be requested. • Cannot be 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
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	$128.00	$128.00	$0.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. D4342 and D1110 can be reported on same service date when date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 can only be charged once, not per quadrant; A diagnosis of periodontitis with clinical attachment loss (CAL) included. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting.. Documentation of other treatment provided at same time will be requested. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

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

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.

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.

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.

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.
Repair broken complete denture base, mandibular	D5511	$123.70	$113.70	$10.00	Repair broken complete denture base, mandibular
Repair broken complete denture base, maxillary	D5512	$123.70	$113.70	$10.00	Repair broken complete denture base, maxillary
Replace missing or broken teeth - complete denture (each tooth)	D5520	$92.91	$82.91	$10.00	Replacement/repair of missing or broken teeth.
Repair resin partial denture base, mandibular	D5611	$95.00	$85.00	$10.00	Repair resin partial denture base, mandibular
Repair resin partial denture base, maxillary	D5612	$95.00	$85.00	$10.00	Repair resin partial denture base, maxillary
Repair cast partial framework, mandibular	D5621	$121.29	$111.29	$10.00	Repair cast partial framework, mandibular
Repair cast partial framework, maxillary	D5622	$121.29	$111.29	$10.00	Repair cast partial framework, 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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Replace broken teeth-per tooth	D5640	$94.02	$84.02	$10.00	Repair/replacement of missing tooth.
Add tooth to existing partial denture	D5650	$109.00	$99.00	$10.00	Adding tooth to partial denture base. Documentation may be requested when charged on partial delivered in last 12 months.
Add clasp to existing partial denture	D5660	$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.
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.
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.

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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.
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 removal of tooth structure, including minor smoothing of socket bone, and closure as necessary. Treatment notes must include documentation that an extraction was done per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$172.88	$162.88	$10.00	Includes removal of bone, and/or sectioning of erupted tooth, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth.
Removal of impacted tooth-soft tissue	D7220	$207.25	$187.25	$20.00	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32 One of D7220 per 1 lifetime per patient per tooth
Removal of impacted tooth-partially bony	D7230	$255.53	$235.53	$20.00	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32 One of D7230 per 1 lifetime per patient per tooth
Removal of impacted tooth-completely bony	D7240	$296.38	$276.38	$20.00	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32 One of D7240 per 1 lifetime per patient per tooth.
Removal of impacted tooth-completely boney, with unusual surgical complications	D7241	$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 One of D7241 per lifetime per patient per tooth.
Surgical removal of residual tooth roots (cutting procedure)	D7250	$182.30	$172.30	$10.00	Includes removal of bone, and/or sectioning of residual tooth roots, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth. Can only be charged once per tooth. Cannot be charged for removal of broken off roots for recently extracted tooth.

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	Removing tissue for histologic evaluation. Treatment notes must include documentation and proof that biopsy was sent for evaluation.
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	$150.00	$140.00	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	$139.42	$129.42	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	$200.47	$190.47	$10.00	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	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	Removal of a benign bony outgrowth (bone spur) for proper prosthesis fabrication. Reported per arch.
Removal of torus palatinus	D7472	$341.08	$331.08	$10.00	To remove a malformation of bone for proper prosthesis fabrication.
Removal of torus mandibularis	D7473	$332.69	$322.69	$10.00	To remove a malformation of bone for proper prosthesis fabrication.
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Palliative (emergency) treatment of dental pain - 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	$40.90	$40.90	$0.00	One of D9219 or D9310 per 12 month(s) per provider or location
Deep sedation/general anesthesia-each 15 minute increment	D9223	$103.40	$93.40	$10.00	Ten of D9223 per 1 day per patient. Not allowed with D9243
Intravenous moderate (conscious)sedation/analgesia-each 15 minute increment	D9243	$103.40	$93.40	$10.00	Fourteen of D9243 per 1 day per patient. Not allowed with D9223

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

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

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