THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960.
Rule Number: MSB 15-10-27-A
Division / Contact / Phone: Special Financing / Chandra Vital / 303-866-5506

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 15-10-27-A, Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960.
3. This action is an adoption of:	An amendment

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

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

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

PUBLICATION INSTRUCTIONS*

Replace all current text beginning at §8.960.1 through the end of the "Definition" section with the new text provided. Replace current text at §8.960.3.E.1 with new text provided. Replace current text at §8.960.3.E.3 with new text provided. The attached appendix should be published at the end of section 8.900 following §8.960.3.F.4. All text indicated in blue is for clarification purposes only and should not be changed. This revision is effective 04/30/2016.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960.
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STATEMENT OF BASIS AND PURPOSE

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

   Concerns were raised by the Office of Legislative Legal Services that the rule did not adequately describe covered dental services as required by statute. This rule change clarifies the descriptions of covered dental services to ensure compliance with statute. Covered dental services include diagnostic imaging, emergency, endodontics, evaluations, oral and maxillofacial surgery, palliative, periodontal, preventive, prophylaxis, removable prosthesis, and restorative services.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   N/A

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015); 25.5-3-404, C.R.S. (2015)

Initial Review	**02/12/2016**	Final Adoption	**03/11/2016**
Proposed Effective Date	**04/30/2016**	Emergency Adoption	

DOCUMENT #01

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Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960.
Rule Number: MSB 15-10-27-A
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REGULATORY ANALYSIS

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

   This rule makes a change to clarify definitions only and does not change services or costs under the current program. Therefore, there is no effect on existing program policy, covered services, or eligible seniors.

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 makes a change to clarify definitions only and does not change services or costs under the current program. Therefore there is no economic effect on program grantees or eligible seniors.

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

   This rule makes a change to clarify definitions only and does not change costs under the current program. Therefore, there are no additional costs to the Department or any other agency.

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

   This rule makes a change to clarify definitions only. There are no changes to existing program policy, covered services, or eligible seniors. If action is not taken, the rule will not be compliant with statute.

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

This rule change is necessary to clarify covered services to comply with statute. This rule does not impose additional costs on program grantees, eligible seniors, or local or state agencies.

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

   This rule change is necessary to clarify the descriptions of covered dental services to ensure compliance with statute. There are no alternatives to amending the existing rule.

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. ~~mean the Current Dental Terminology (CDT) procedure codes and descriptions for the Colorado Dental Health Care Program for Low-Income Seniors as published on the Department's website at https://www.colorado.gov/hcpf/research-data-and-grants.~~

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. (2014).

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 means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is able to demonstrate lawful presence in the state in accordance with 1 CCR 201-17, 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.

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.

Evaluation means a patient 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).

~~Fee Schedule means the and descriptions for the Colorado Dental Health Care Program for Low-Income Seniors as published on the Department's website at https://www.colorado.gov/hcpf/research-data-and-grants.~~

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 Patient Co-Pay.

Max Patient 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. (2014).

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. (2014)

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 (gum) 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.

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. (2014);
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 patient.

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

Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2014).

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. (2014).

8.960.3 Request of Grant Proposals and Grant Award Procedures

8.960.3.A Request for Grant Proposals

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

8.960.3.B Evaluation of Grant Proposals

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

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

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

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

   a. Outreach to and identify Eligible Seniors;

   b. Collaborate with community-based organizations; and

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

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

8.960.3.C Grant Awards

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

8.960.3.D Qualified Grantee Responsibilities

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

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

2. Demonstrate collaboration with community-based organizations;

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

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

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

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

7. Submit an annual report as specified under 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 ~~the published Fee Schedule for provided~~Appendix A ~~types of Covered Dental Care Services provided~~, and any other information required by the Department.

2. The Department will pay no more than the established Program Payment per procedure rendered.

3. ~~It is up to the discretion of Qualified Providers whether to charge a co-payment. Under no circumstance shall~~ Eligible Seniors shall not be charged more than the Max Patient Co-Pay as listed in Appendix A~~per procedure rendered~~.

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

8.960.3.F Annual Report

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

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

1. The number of Eligible Seniors served;
2. The types of Covered Dental Care Services provided;
3. An itemization of administrative expenditures; and
4. Any other information deemed relevant by the Department.

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Periodic oral evaluation - established patient	D0120	$46.00	$46.00	$0.00	Evaluation on patient of record to determine changes in medical or dental status since last evaluation. Includes oral cancer evaluation, periodontal evaluation, diagnosis, treatment planning. Frequency: One time per 6 month period per patient; 2 week window accepted.
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 w/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. Should not be used for adjustments made to prosthesis provided within previous 12 months. Should not be used as an encounter fee.
Comprehensive Oral Evaluation - new or established patient	D0150	$81.00	$81.00	$0.00	Evaluation used by general dentist or specialist. Applicable to new patients or established patients w/significant health changes, or absence from active treatment

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					for more than 5 years. This includes a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, and an evaluation and recording of the patient'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 5 years per patient. Should not be charged on the same date as D0180.
Comprehensive Periodontal Evaluation - new or established patient	D0180	$88.00	$88.00	$0.00	Evaluation for patients presenting signs & symptoms of periodontal disease & patients w/risk factors such as smoking or diabetes. This evaluation encompasses a comprehensive oral exam, and full, complete & detailed periodontal charting. Frequency: 1 per 3 years per patient. Should not be charged on the same date as D0150.
Intraoral - complete series of radiographic images	D0210	$125.00	$125.00	$0.00	Radiographic survey of whole mouth, 6-22 periapical & posterior bitewing images displaying 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 w/in 60 days of a full month series or a panoramic film is not covered unless there is evidence of

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					trauma. Frequency: 1 per 5 years per patient. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 should 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 patient. Report additional radiographs as D0230. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.
Intraoral - periapical each additional radiographic image	D0230	$23.00	$23.00	$0.00	D0230 should be utilized for additional films taken beyond D0220. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
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, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					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, or D0274 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, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - four radiographic images	D0274	$60.00	$60.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 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 patient. Should not be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 yrs.

Procedure Description	**Alpha-numeric Code**	**Max Allowable Fee**	**Program Payment**	**Max Patient 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. Prophylaxis is not a benefit when billed on the same date of service as any periodontal procedure code. Frequency: 1 time per 6 calendar months; 2 week window accepted. May be billed for routine prophylaxis for areas of mouth not periodontally involved. Should not be billed in addition to code D4910 for periodontal maintenance. D1110 may be billed w/ D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth not receiving nonsurgical periodental therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease. D1110 should only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed. Should not be alternated w/D4910 for maintenance of periodontally-involved individuals. Should not be used as 1 month re-evaluation following nonsurgical periodontal therapy.
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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. Should not 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 w/prophylaxis or preventive appointment. Frequency: one (1) time per 12 calendar months. Should not be used wD1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
Amalgam - one surface, primary or permanent	D2140	$107.00	$97.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included.
Amalgam - two surfaces, primary or permanent	D2150	$138.00	$128.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Amalgam - three surfaces, primary or permanent	D2160	$167.00	$157.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Amalgam - four or more surfaces, primary or permanent	D2161	$203.00	$193.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite - one surface, anterior	D2330	$115.00	$105.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Resin-based composite - two surfaces, anterior	D2331	$146.00	$136.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite - three surfaces, anterior	D2332	$179.00	$169.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
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, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite - one surface, posterior	D2391	$134.00	$124.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite -two surfaces, posterior	D2392	$176.00	$166.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite - three surfaces, posterior	D2393	$218.00	$208.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration.
Resin-based composite - four or more surfaces, posterior	D2394	$268.00	$258.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, polishing, and bases. Adjustments are included. Frequency: 36 months for the

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					same restoration.
Crown - porcelain/ceramic substrate	D2740	$780.00	$730.00	$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and 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	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and 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	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to noble metal	D2752	$780.00	$730.00	$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					patient per tooth. Second molars are only covered if it meets criteria and 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	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and 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	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and 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	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast high noble metal	D2790	$780.00	$730.00	$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782,

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and 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	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and 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	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - titanium	D2794	$780.00	$730.00	$50.00	One of (D2710, D2712, D2721, D2722, D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 84 month(s) per patient per tooth. Second molars are only covered if it meets criteria and 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 Patient 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	
Core buildup, including any pins when required	D2950	$225.00	$200.00	$25.00	One of (D2950, D2952, D2954) per 84 month(s) per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. 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. Should 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	One of (D2950, D2952, D2954) per 84 month(s) per patient per tooth. 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	One of (D2950, D2952, D2954) per 84 month(s) per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	$566.40	$516.40	$50.00	Teeth covered - 6-11, 22-27.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Endodontic therapy, bicuspid tooth (excluding final restoration)	D3320	$661.65	$611.65	$50.00	Teeth covered - 4,5,12,13,20,21,28, and 29.
Endodontic therapy, molar (excluding final restoration)	D3330	$786.31	$736.31	$50.00	Teeth covered - 2,3,14,15,18,19,30, and 31.
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 patients w/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 may only be charged once, not per quadrant. A diagnosis of periodontitis w/clinical attachment loss (CAL) included. Diagnosis and classification of the periodontology case type must be in accordance w/documentation as currently established by the American Academy of Periodontology. Current periodontal charting must be present in patient chart documenting active periodontal disease. Frequency: 1 time per quadrant per 36 month interval. When 4 quadrants are completed in a single visit, consideration should be taken for individual's ability to withstand extended treatment

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					time. Documentation of other treatment provided at same time will be requested. Should include any follow-up and re-evaluation.
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 patients w/periodontal disease and is therapeutic, not prophylactic. D4341 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 may only be charged once, not per quadrant. A diagnosis of periodontitis w/clinical attachment loss (CAL) included. Current periodontal charting must be present in patient chart documenting active periodontal disease. Frequency: 1 time per quadrant per 36 month interval. When 4 quadrants are completed in a single visit, consideration should be taken for individual's ability to withstand extended treatment time. Documentation of other treatment provided at same time will be requested. Should include any follow-up and re-evaluation

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Periodontal maintenance procedures	D4910	$136.00	$136.00	$0.00	Procedure following periodontal therapy (D4341,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. If D1110 is once again reported then scaling and root planing will be required to use D4910. Frequency: up to four (4) times per fiscal year per patient. Should not be charged alternating with D1110. Cannot be charged w/in the first three months following active periodontal treatment.
Complete denture - maxillary	D5110	$793.00	$713.00	$80.00	Reimbursement made upon DELIVERY (completed) maxillary denture. D5110 or D5120 should not be used to report an immediate denture. Immediate denture (D5130, D5140) OR interim complete denture (D5810, D5811) is inserted immediately after extraction of teeth and is not currently covered on the OAP Dental Program Provider Reimbursement Schedule. Routine follow-up adjustments/relines w/in 12 months should 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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon patient, oral health, overall health, and other confounding factors. Frequency: There should be an expected life span of 5-10 years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.
Complete denture - mandibular	D5120	$793.00	$713.00	$80.00	Reimbursement made upon DELIVERY (completed) mandibular denture. D5110 or D5120 should not be used to report an immediate denture. Immediate denture (D5130, D5140) OR interim complete denture (D5810, D5811) is inserted immediately after extraction of teeth and is not currently covered on the OAP Dental Program Provider Reimbursement Schedule. Routine follow-up adjustments/relines w/in 12 months should 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.

Procedure Description	**Alpha-numeric Code**	**Max Allowable Fee**	**Program Payment**	**Max Patient Co-Pay**	**PROGRAM GUIDELINES**
					This can vary greatly depending upon patient, oral health, overall health, and other confounding factors. Frequency: There should be an expected life span of 5-10 years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.
Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	D5211	$700.00	$640.00	$60.00	Reimbursement made upon DELIVERY (completion) of partial maxillary denture. D5211 or D5212 should not be used to report an interim partial denture (D5820, D5821). D5211 and D5212 should be considered definitive treatment. Routine follow-up adjustments or relines within 12 months should 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 as extensive as healing from multiple). A 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" appts may be necessary and are included in the cost. Frequency: There should be an expected life span of 5 - 10 years before replacement dentures should be considered -

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					documentation that existing prosthesis cannot be made serviceable should be maintained.
Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	D5212	$778.00	$718.00	$60.00	Reimbursement made upon DELIVERY (completion) of partial mandibular denture. D5211 or D5212 should not be used to report an interim partial denture (D5820, D5821). D5211 and D5212 should be considered definitive treatment. Routine follow-up adjustments/relines within 12 months should 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 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" appts may be necessary and are included in the cost. Frequency: There should be an expected life span of 5 - 10 years before replacement dentures should be considered - documentation that existing prosthesis cannot be made serviceable should be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Repair *Broken complete denture base	D5510	$87.00	$77.00	$20.00	Repair *Broken complete denture base.
Replace missing or *Broken teeth - complete denture (each tooth)	D5520	$73.00	$63.00	$10.00	Replacement/repair of missing or *Broken teeth.
Repair resin denture base	D5610	$95.00	$85.00	$10.00	Repair of upper/lower partial denture base.
Repair or replace *Broken clasp	D5630	$123.00	$113.00	$10.00	Repair of *Broken clasp on partial denture base.
Replace *Broken teeth-per tooth	D5640	$80.00	$70.00	$10.00	Repair/replacement of missing tooth.
Add tooth to existing partial denture	D5650	$109.00	$99.00	$10.00	Adding tooth to partial denture base. Documentation may be requested when charged on partial delivered in last 12 months.
Add clasp to existing partial denture	D5660	$131.00	$121.00	$10.00	Adding clasp to partial denture base. 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. May not be charged on denture provided in the last 12 months. May not be charged in addition to a reline in a 12 month period.
Rebase complete mandibular denture	D5711	$308.00	$283.00	$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. May not be charged on denture provided in

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
					the last 12 months. May not 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. May not be charged on denture provided in the last 12 months. May not be charged in addition to a reline in a 12 month period.
Rebase mandibular partial denture	D5721	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. May not be charged on denture provided in the last 12 months. May not 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 w/out processing denture base. Frequency: One (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not 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 w/out processing denture base. Frequency: One (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture	D5740	$167.00	$157.00	$10.00	Chair side reline that resurfaces w/out processing partial denture base. Frequency: one

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
(chairside)					(1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (chairside)	D5741	$167.00	$157.00	$10.00	Chair side reline that resurfaces w/out processing partial denture base. Frequency: one (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Reline complete maxillary denture (laboratory)	D5750	$243.00	$218.00	$25.00	Laboratory reline that resurfaces w/processing denture base. Frequency: one (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not 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 w/processing denture base. Frequency: one (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not 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. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
Reline mandibular partial denture (laboratory)	D5761	$239.00	$214.00	$25.00	Laboratory reline that resurfaces w/processing partial denture base. Frequency: one (1) time per 12 months. May not be charged on denture provided in the last 12 months. May not be charged in addition to a rebase in a 12 month period.
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	$82.00	$72.00	$10.00	Routine removal of tooth structure, including minor smoothing of socket bone, and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth.
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$135.00	$125.00	$10.00	Includes removal of bone, and/or sectioning of erupted tooth, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth.
Surgical removal of residual tooth roots (cutting procedure)	D7250	$143.00	$133.00	$10.00	Includes removal of bone, and/or sectioning of residual tooth roots, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth. May only be charged once per tooth. May not be charged for removal of broken off roots for recently extracted tooth.
Incisional biopsy of oral	D7286	$381.00	$381.00	$0.00	Removing tissue for histologic evaluation. Treatment notes

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Patient Co-Pay	PROGRAM GUIDELINES
tissue-soft					must include documentation and proof that biopsy was sent for evaluation.
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	$150.00	$140.00	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	$138.00	$128.00	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	$150.00	$140.00	$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	$138.00	$128.00	$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
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 Patient Co-Pay**	**PROGRAM GUIDELINES**
Palliative (emergency) treatment of dental pain - minor procedure	D9110	$61.00	$36.00	$25.00	Emergency treatment to alleviate pain/discomfort. This code should not be used for file claims for 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.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Finance Office Payment Reform Section Hospital Services Rule Concerning definition for Trim Point Day, Section 8.300.1
Rule Number: MSB 15-11-20-A
Division /Contact/Phone: Finance/Payment Reform/Diana Lambe 303.866.5526

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: Revision to the Medical Assistance Finance Office Payment Reform Section Hospital Services Rule Concerning definition for Trim Point Day, Section 8.300.1
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) 8.300.1 Page 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)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text at the 26th unnumbered paragraph that begins "Trim Point Day. ." at §8.300.1 with new text provided. This revision is effective 04/30/2016.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

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

   Rule Change being requested: Trim Point Day (Outlier Threshold Day) means the day which would occur ~~1.94~~ 2.58 standard deviations above the mean (average) length of stay (ALOS) for each DRG (Diagnosis Related Group).

   Quick Overview: The fact of the matter is that this definition should have been updated in 1/1/2014 when the Department introduced APR-DRGs (All Patient Refined DRGs) to the Inpatient Hospitals Prospective Payment System.

   The 1.94 standard deviations were related to when the Department had CMS-DRGs (Centers for Medicare and Medicaid DRG – largely senior patient population). During the implementation of APR-DRGs (patient population consists of all ages), stakeholders were made aware of and given opportunity to comment on the 2.58 standard deviations that were ultimately used on May 2, 2013.

   When and why should rule be changed? The reason the Department altered the standard deviation in 1/1/2014 when changing from CMS-DRGs was because APR-DRGs offered the additional Severity of Illness calibration which was missing from CMS-DRGs. This additional criteria allowed for longer stays in hospital for those who were deemed "sicker" than others thereby eliminating the one size fits all approach per DRG the Department had with CMS-DRGs. This rule needs to be updated as soon as possible in order for rule to reflect actual practice.

   Stakeholder feedback: We do not anticipate any concern from stakeholders since this change has been vetted back in May 2013 and in practice for several years now.

   Budgetary Impact: None. The implementation of APR-DRGs in 1/1/2014 were implemented in a budget neutral manner.

   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.

Initial Review	**02/12/2016**	Final Adoption	**03/11/2016**
Proposed Effective Date	**04/30/2016**	Emergency Adoption	

DOCUMENT #02

Explain:

2. Federal authority for the Rule, if any:

   42 C.F.R. 412

3. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015); 25.5-4-401, CRS (2015)

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REGULATORY ANALYSIS

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

   There should be no ill-effects of this rule change since APR-DRGs were implemented in a budget neutral manner. This is a technical update to the rule to correct a prior oversight. Implementation of the 2.58 standard deviations occurred in 2014, so the correction of this error will not result in costs or benefits to stakeholders.

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

   The reason the Department altered the standard deviation in 1/1/2014 when changing from CMS-DRGs was because APR-DRGs offered the additional Severity of Illness calibration which was missing from CMS-DRGs. This additional criteria allowed for longer stays in hospital for those who were deemed "sicker" than others thereby eliminating the one size fits all approach per DRG the Department had with CMS-DRGs. These changes were implemented in 2014, so correction of the rule now will have no effect on any class of person.

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.

   APR-DRGs were implemented in a budget neutral manner on 1/1/2014. This rule is merely a correction to bring the regulation into alignment with current practice. It will not result in any additional costs to the Department or any other agency.

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

   The cost of inaction is the potential for a challenge to current reimbursement practices based on the erroneous rule. There is no benefit to inaction. No costs are associated with correcting to the rule to align with current practice. The benefit of

such alignment is the elimination of the potential for a challenge to current practice based on the error in the rule.

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

   A rule change is the only way to bring rule in line with actual practice.

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.

   A rule change is the only way to bring rule in line with actual practice.

8.300 HOSPITAL SERVICES

8.300.1 Definitions

Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves against medical advice.

Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service during the course of treatment.

Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient health care procedure, treatment or service.

Department means the Department of Health Care Policy and Financing.

Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize similar amounts of Hospital resources.

DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access Hospitals, Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals.

Diagnostic Services means any medical procedures or supplies recommended by a licensed professional within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or extent of illness, injury or other health condition in a client.

Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals receive for serving a disproportionate share of low-income clients.

Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, for which the absence of immediate medical attention could reasonably be expected to result in: (1) placing the client’s health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a Hospital by the Colorado Department of Public Health and Environment (CDPHE); and, when not located in Colorado, by the state in which it is located; and (3) certified for participation in the Centers for Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program, distinct part units and satellite locations are considered part of the Hospital under which they are licensed. Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado Medicaid program. Types of Hospitals are:

> A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.

A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital. CAHs offer emergency services and limited Inpatient care. CAHs may offer limited surgical services and/or obstetrical services including a delivery room and nursery.

A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital providing care primarily to populations aged seventeen years and under.

A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.

A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital. In general, Long-Term Care Hospitals have an average length of stay of greater than twenty-five (25) days.

A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is operated by the Colorado Department of Human Services.

Inpatient means a person who is receiving professional services at a Hospital; the services include a room and are provided on a continuous 24-hour-a-day basis. Generally, a person is considered an Inpatient by a physician's order if formally admitted as an Inpatient with the expectation that the client will remain at least overnight and occupy a bed even though it later develops that the client can be discharged or transferred to another Hospital and does not actually use a bed overnight.

Inpatient Hospital Services means preventive, therapeutic, surgical, diagnostic, medical and rehabilitative services that are furnished by a Hospital for the care and treatment of Inpatients and are provided in the Hospital by or under the direction of a physician.

Medically Necessary, or Medical Necessity, means a Medicaid service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals are considered Non-DRG Hospitals since their reimbursement is based on a per diem rate.

Observation Stay means a stay in the Hospital for no more than forty-eight hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed twenty-four hours in length.

Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.

Outpatient means a client who is receiving professional services at a Hospital, which is not providing him/her with room and board and professional services on a continuous 24-hour-a-day basis.

Outpatient Hospital Services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist.

Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service prior to treatment.

Rehabilitative Services means any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a client to his/her best possible functional level.

Relative Weight (DRG weight) means a numerical value which reflects the relative resource consumption for the DRG to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost of claims for each DRG. Relative Weights are intended to be cost effective, and based upon Colorado data as available.

Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service following treatment. A Retrospective Review can occur before or after reimbursement has been made.

Rural Hospital means a Hospital not located within a metropolitan statistical area (MSA) as designated by the United States Office of Management & Budget.

State University Teaching Hospital means a Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education; and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

Swing Bed Designation means designation of Hospital beds in a Rural Hospital with less than 100 beds for reimbursement under Medicare for furnishing post-hospital extended care services to Medicare beneficiaries in compliance with the Social Security Act, Sections 1883 and 1866. Such beds are called "swing beds."

Trim Point Day (Outlier Threshold Day) means the day which would occur ~~1.94~~2.58 standard deviations above the mean (average) length of stay (ALOS) for each DRG.

Urban Hospital means a Hospital located within a MSA as designated by the United States Office of Management & Budget.

Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Health Programs Benefits Management Rule Concerning Supervision Requirements for Registered Nurses at Local Public Health Agencies, Section 8.200
Rule Number: MSB 15-05-27-E
Division/Contact/Phone: Health Programs Benefits and Operations Division / Richard Delaney x3436 / Amanda Forsythe x6459

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 15-05-27-E, Revision to the Medical Assistance Health Programs Benefits Management Rule Concerning Supervision Requirements for Registered Nurses at Local Public Health Agencies, Section 8.200
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) 8.200, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace current text beginning at §8.200.1 DEFINITIONS through the end of §8.200.2.D.1.a with the new text provided. All text indicated in blue is for clarification purposes only and should not be changed. This change is effective 04/30/2016.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Health Programs Benefits Management Rule Concerning Supervision Requirements for Registered Nurses at Local Public Health Agencies, Section 8.200
Rule Number: MSB 15-05-27-E
Division/Contact/Phone: Health Programs Benefits and Operations Division / Richard Delaney x3436 / Amanda Forsythe x6459

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule revises the supervision requirements for vaccination administration services rendered by a Registered Nurse (RN) at a Local Public Health Agency (LPHA). The proposed revision removes the requirement that the supervising provider be physically onsite for the duration of vaccination administration services rendered by RNs, and replaces it with a requirement that the supervising provider be immediately available via telephonic or other electronic means to give assistance throughout the performance of the service. This rule revision is intended to increase access to vaccinations for Colorado Medicaid clients served by LPHAs.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 440.230(b); 42 CFR 440.60(a); and 42 CFR 440.130(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   24-4-103(6)(a), C.R.S. (2015); 25.5-4-401(2), C.R.S. (2015)

Initial Review | Final Adoption **03/11/2016**
Proposed Effective Date **04/30/2016** | Emergency Adoption

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Health Programs Benefits Management Rule Concerning Supervision Requirements for Registered Nurses at Local Public Health Agencies, Section 8.200

Rule Number: MSB 15-05-27-E

Division/Contact/Phone: Health Programs Benefits and Operations Division / Richard Delaney x3436 / Amanda Forsythe x6459

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 persons affected are Colorado Medicaid clients. All Colorado Medicaid clients may receive vaccinations from Local Public Health Agencies.

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

   The proposed rule revision will increase access to vaccinations for Colorado Medicaid clients. It is impossible to determine the exact extent to which this rule revision will result in an increase to the number of vaccinations administered. There is no possibility that this rule revision will result in a decrease in vaccination administration.

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 implementation and enforcement of the proposed rule change will be limited to the Department. The rule change does not affect the $16.28 per-shot vaccination administration fee, which will remain as is. Utilization may increase, but as LPHAs accounted for only 2.5% of all fee schedule-paid vaccinations during flu season last year, the anticipated cost to the Department is minimal. The best estimate is that the rule change will increase Department costs for LPHA vaccination administration services by 10% above last year, adding a total of $1,000 to the Department's budget.

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

   The probable costs are relatively small, and prevention of flu cases in the population will offset the additional vaccination administration costs.

THIS PAGE NOT FOR PUBLICATION

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

   There is no alternative way to expand vaccination administration to the population of clients seen at LPHAs by RNs providing the services under general supervision.

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

   The alternative method considered by the Department was to retain the existing direct supervision requirements at Section 8.200.D. However, this alternative was not seen as good policy at the Department, as it would not achieve the purpose of ensuring client access to vaccination administration services at LPHAs.

8.200 PHYSICIAN SERVICES

8.200.1 DEFINITIONS

An Advanced Practice Nurse is a provider that meets the requirements to practice advanced practice nursing as defined in Article 38 of Title 12 of the Colorado Revised Statutes. In Colorado an Advanced Practice Nurse may have prescriptive authority.

A Licensed Psychologist is a provider that meets the requirements to practice psychology as defined in Part 3 of Article 43 of Title 12 of the Colorado Revised Statutes.

Certified Family Planning Clinic means a family planning clinic certified by the Colorado Department of Public Health and Environment, accredited by a national family planning organization and staffed by medical professionals licensed to practice in the State of Colorado, including but not limited to, doctors of medicine, doctors of osteopathy, physicians' assistants and advanced practice nurses.

Direct Supervision means the supervising provider shall be on-site during the rendering of services and immediately available to give assistance and direction throughout the performance of the service.

General Supervision means the supervising provider need not be on-site during the rendering of services, but needs to be immediately available via telephonic or other electronic means to give assistance and direction throughout the performance of the service.

Medical Necessity is defined in 10 C.C.R. 2505-10, Section 8.076.1.8.

8.200.2 PROVIDERS

8.200.2.A A doctor of medicine or a doctor of osteopathy may order and provide all medical care goods and services within the scope of their license to provide such goods and services that are covered benefits of the Colorado Medical Assistance Program.

1. A provider of covered dental care surgery can be either enrolled as a dentist or oral surgeon, but not both. A dentist may order and provide covered dental care.

8.200.2.B Physician services that may be provided without a physician order by non-physician providers.

1. Advanced Practice Nurses may provide and order covered goods and services in accordance with the scope of practice as described in the Colorado Revised Statutes without a physician order.

2. Licensed Psychologists may provide and order covered mental health goods and services in accordance with the scope of practice as described in the Colorado Revised Statutes without a physician order.

    a. Services ordered by a Licensed Psychologist but rendered by another provider shall be signed and dated by the Licensed Psychologist contemporaneously with the rendering of the service by a non-licensed mental health provider.

3. Optometrists may provide covered optometric goods and services within their scope of practice as described by the Colorado Revised Statutes without a physician order.

4. Podiatrists may provide covered foot care services within their scope of practice as described by the Colorado Revised Statutes without a physician order.

5. Licensed dental hygienists may provide unsupervised covered dental hygiene services in accordance with the scope of practice for dental hygienists as described in the Colorado Revised Statutes without a physician order.

   a. Unsupervised dental hygiene services are limited to those clients and procedures as defined by the Department of Health Care Policy and Financing.

8.200.2.C Physician services that may be provided by a non-physician provider when ordered by a provider acting under authority described in Sections 8.200.2.A and 8.200.2.B.

1. Registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, and licensed physician assistants may provide services ordered by a physician.

   a. Services shall be rendered and supervised in accordance with the scope of practice for the non-physician provider described in the Colorado Revised Statutes.

8.200.2.D Physician services that may be provided when supervised by an enrolled provider.

1. With the exception of the non-physician providers described in Sections 8.200.2.A through 8.200.2.C and 8.200.2.D.1.a, a non-physician provider may provide covered goods and services only under the Direct Supervision of an enrolled provider who has the authority to supervise those services, according to the Colorado Revised Statutes. If the Colorado Revised Statutes do not designate who has the authority to supervise, the non-physician provider shall provide services under the Direct Supervision of an enrolled physician.

~~a. Direct Supervision means the supervising provider shall be on-site during the rendering of services and immediately available to give assistance and direction throughout the performance of the service.~~

   a. Registered Nurses (RNs) employed by Local Public Health Agencies (LPHAs) may provide vaccination administration services under General Supervision.

8.200.2.E Licensure and required certification for all physician service providers shall be in accordance with their specific specialty practice act and with current state licensure statutes and regulations.

8.200.3. BENEFITS

8.200.3.A Physician services are reimbursable when the services are a benefit of Medicaid and meet the criteria of Medical Necessity as defined in 10 C.C.R. 2505-10, Section 8.076.1.8 and are provided by the appropriate provider specialty.

1. Physician services in dental care are a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fraction of the jaw or facial bones. Service includes dental splints or other devices.

2. Outpatient mental health services are provided as described in 10 CCR 2505-10, Section 8.212.

3. Physical examinations are a benefit when they meet the following criteria:

a. Physical examinations are a benefit for preventive service, diagnosis and evaluation of disease or early and periodic screening, diagnosis and treatment for clients under the age of 21 as described in 10 C.C.R. 2505-10, Section 8.280.

b. Physical examination as a preventive service for adults is a benefit limited to one per state fiscal year.

4. Physician services for the provision of immunizations are a benefit. Vaccines provided to enrolled children that are eligible for the Vaccines for Children program shall be obtained through the Colorado Department of Public Health and Environment.

5. Physician services for laboratory testing described in 10 C.C.R. 2505-10, Section 8.660, are a benefit.

6. Occupational and physical therapy services are benefits.

7. Family planning services described in 10 C.C.R. 2505-10, Section 8.730 are benefits.

8.200.3.B Telemedicine is the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio, interactive video or interactive data communication instead of in-person contact.

1. Physician services may be provided as telemedicine.

2. Any health benefits provided through telemedicine shall meet the same standard of care as in-person care.

8.200.3.C Services and goods generally excluded from coverage are identified in 10 C.C.R. 2505-10, Section 8.011.11.

8.200.3.C.2 Immunization Services Benefit Coverage Standard

All providers of vaccines through the Vaccines for Children program or the Colorado Immunization Program shall be in compliance with the Colorado Medicaid Immunization Services Benefit Coverage Standard (approved April 2, 2012), incorporated by reference. The incorporation of the Immunization Services Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative web site at Colorado.gov/hcpf. Click “Boards & Committees,” and click “Benefits Collaborative,” and click “Approved Benefit Coverage Standards.” 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, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.200.3.D Physician Services Benefit Coverage Standards

Note: 8.200.3.D.1 Podiatry Services Benefit Coverage Standard was moved to §8.810 01/2015.

2. Speech – Language and Hearing Services Benefit Coverage Standard

a. ELIGIBLE PROVIDERS

i. Eligible providers include individual practitioners and those employed by home care agencies, children’s developmental service agencies, health

departments, federally qualified health centers (FQHC), clinics, or hospital outpatient services.

ii. Otolaryngologists, speech-language pathologists (speech therapists), and audiologists shall have a current and active license or registration and be current, active and unrestricted to practice.

iii. Providers shall be enrolled as a Colorado Medicaid provider in order to be eligible to bill for procedures, products and services in treating a Colorado Medicaid client.

iv. Rendering Providers include:

1. Otolaryngologist

2. Speech-language pathologist

3. Speech-language pathology assistant

4. Clinical fellows

5. Audiologist

b. PROVIDER AGENCY REQUIREMENTS

i. Providers of in-home health who employ therapists or audiologists shall apply for licensing through the Colorado Department of Public Health and Environment (CDPHE). (§25-27.5-103(1) C.R.S. and 6 CCR 1011-1, Chapter XXVI, Section 5.1) as a home **care** agency.

ii. This rule does not apply to providers delivering Early Intervention Services under an Individual Family Service Plan (IFSP) and billing through contracts with the Community Centered Boards.

c. ELIGIBLE PLACES OF SERVICE

i. Eligible Places of Service shall include:

1. Office

2. Home

3. School

4. FQHC

5. Outpatient Hospital

6. Community Based Organization

d. ELIGIBLE CLIENTS

i. Eligible Clients include enrolled clients ages twenty (20) and under and adult clients who qualify under medically necessary services. Qualifying adult clients may receive services for non-chronic conditions and acute illness and injuries.

e. COVERED SERVICES

i. Newborn Screening

1. Screening shall include a comprehensive health assessment performed soon after birth or as early as possible in a child's life and repeated at periodic intervals of time as recommended by the Colorado Early & Periodic Screening & Diagnostic and Treatment (EPSDT) periodicity schedules.

ii. Early Language Intervention

1. Early language intervention for children 0 through three with a hearing loss may be provided by audiologists, speech therapists, or Colorado Home Intervention Program (CHIP) providers.

iii. Audiology Services

1. Audiological benefits include identification, diagnostic evaluation and treatment for children with hearing loss, neurologic, dizziness/vertigo, or balance disorders. Conditions treated may be either congenital or acquired.

2. Assessment – Service may include testing or clinical observation or both, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report.

a. Auditory sensitivity (including pure tone air and bone conduction, speech detection and speech reception thresholds).

b. Auditory discrimination in quiet and noise.

c. Impedance audiometry (tympanometry and acoustic reflex testing).

d. Hearing aid evaluation (amplification selection and verification).

e. Central auditory function.

f. Evoked otoacoustic emissions.

g. Brainstem auditory evoked response.

h. Assessment of functional communicative skills to enhance the activities of daily living.

i. Assessment for cochlear implants (for clients ages 20 and under).

j. Hearing screening.

k. Assessment of facial nerve function.

l. Assessment of balance function.

m. Evaluation of dizziness/vertigo.

3. Treatment – Service may include one or more of the following, as appropriate:

   a. Auditory training.

   b. Speech reading.

   c. Augmentative and alternative communication training including training on how to use cochlear implants for clients ages 20 and under. Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of Activities of Daily Living.

   d. Purchase, maintenance, repairs and accessories for approved devises.

   e. Selection, testing and fitting of hearing aids for children with bilateral or unilateral hearing loss; and auditory training in the use of hearing aids.

   f. Purchase and training on Department approved assistive technologies.

   g. Balance or vestibular therapy.

iv. Cochlear Implants

1. Cochlear implants may be indicated for clients aged 12 months through 20 years under the following pre-authorization criteria:

   a. Six months of age or older.

   b. Limited benefit from appropriately fitted binaural hearing aids (with different definitions of “limited benefit” for children 4 years of age or younger and those older than 4 years) and a 3-6 month hearing aid trial.

   c. Bilateral hearing loss with unaided pure tone average thresholds of 70 dB or greater.

   d. Minimal speech perception measured using recorded standardized stimuli-speech discrimination scores of 50-60% or below with optimal amplification at 1000, 2000 and 4000 Hz.

   e. Family support and motivation to participate in a post-cochlear aural, auditory and speech language rehabilitation program.

f. Assessment by an audiologist and otolaryngologist experienced in cochlear implants.

g. Bi lateral and hybrid/Electric Acoustic Stimulation cochlear implantation considered on a case by case basis.

h. No medical contraindications.

i. Up-to-date-immunization status as determined by the **Advisory Committee on Immunization Practices (ACIP).**

j. Replacement of an existing cochlear implant for all ages is a benefit when the currently used component is no longer functional and cannot be repaired.

v. Speech-language Services

1. Assessment **–** Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report:

a. Expressive language.

b. Receptive language.

c. Cognition.

d. Augmentative and alternative communication.

e. Voice disorder.

f. Resonance patterns.

g. Articulation/phonological development.

h. Pragmatic language.

i. Fluency.

j. Feeding and swallowing.

k. Hearing status based on pass/fail criteria.

l. Motor speech.

m. Aural rehabilitation (defined by provider's scope of practice.

2. Treatment **–** Service may include one or more of the following, as appropriate:

a. Articulation/phonological therapy

b. Language therapy including expressive, receptive, and pragmatic language.

c. Augmentative and alternative communication therapy. Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of Activities of Daily Living

d. Auditory processing/discrimination therapy

e. Fluency therapy.

f. Voice therapy.

g. Oral motor therapy.

h. Swallowing therapy.

i. Speech reading.

j. Cognitive treatment.

k. Necessary supplies and equipment.

l. Aural rehabilitation (defined by provider's scope of practice)

f. DOCUMENTATION

i. General Requirements for Client's Record of Service:

1. Rendering providers shall document all evaluations, re-evaluations, services provided, client progress, attendance records, and discharge plans. All documentation must be kept in the client's records along with a copy of the referral or prescribing provider's order.

2. Documentation shall support both the medical necessity of services and the need for the level of skill provided.

3. Rendering providers shall copy the client's prescribing provider and medical home/primary care provider on all relevant records.

ii. Documentation shall include all of the following:

1. The client's name and date of birth.

2. The date and type of service provided to the client.

3. A description of each service provided during the encounter including procedure codes and time spent on each.

4. The total duration of the encounter.

5. The name or names and titles of the persons providing each service and the name and title of the therapist supervising or directing the services.

iii. Documentation categories

1. Provider shall keep documentation for the following episodes of care: Initial Evaluation, Re-evaluation, Visit/Encounter Notes, and Discharge Summary.

2. Written documentation of the Initial Evaluation shall include the following:

    a. The reason for the referral and reference source.

    b. Diagnoses pertinent to the reason for referral, including:

        i. Date of onset;

        ii. Any cognitive, emotional, or physical loss necessitating referral, and the date of onset, if different from the onset of the relevant diagnoses;

        iii. Current functional limitation or disability as a result of the above loss, and the onset of the disability;

        iv. Pre-morbid functional status, including any pre-existing loss or disabilities;

        v. Review of available test results;

        vi. Review of previous therapies/interventions for the presenting diagnoses, and the functional changes (or lack thereof) as a result of previous therapies or interventions.

    c. Assessment: Include a summary of the client's impairments, and functional limitations and disabilities, based on a synthesis of all findings gathered from the evaluation. Highlight pertinent factors which influence the treatment diagnosis and prognosis, and discuss the inter-relationship between the diagnoses and disabilities for which the referral was made should be discussed.

    d. Plan of Care: A detailed Plan of Care must include the following

        i. Specific treatment goals for the entire episode of care which are functionally-based and objectively measured.

    e. Proposed interventions/treatments to be provided during the episode of care.

f. Proposed duration and frequency of each service to be provided.

g. Estimated duration of episode of care.

7. The therapist's Plan of Care must be reviewed, revised if necessary, and signed, as medically necessary by the client's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days. The care plan should not cover more than a 90-day period or the time frame documented in the Individual Family Service Plan (IFSP). (Senate bill 07-004 states the IFSP "shall qualify as meeting the standard for medically necessary services." Therefore no physician is required to sign a work order for the IFSP.)

8. A plan of care must be certified. Certification is the physician's, physician's assistant or nurse practitioner's approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. If the service is a Medicare covered service and is provided to a recipient who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

9. Re-evaluation. A re-evaluation must be done whenever there is an unanticipated change in the client's status, a failure to respond to interventions as expected or there is a need for a new Plan of Care based on new problems and goals that require significant changes to the Plan of Care. The documentation for a re-evaluation need not be as comprehensive as the initial evaluation, but must include at least the following: Reason for re-evaluation; Client's health and functional status reflecting any changes; findings from any repeated or new examination elements; and, Changes to plan of care.

iv. Visit/Encounter Notes

1. Written documentation of each encounter must be in the client's record of service. These visit notes document the implementation of the plan of care established by the therapist at the initial evaluation. Each visit note must include the following:

a. The total duration of the encounter.

b. The type and scope of treatment provided, including procedure codes and modifiers used.

c. The time spent providing each service. The number of units billed/requested must match the documentation.

d. Identification of the short or long term goals being addressed during the encounter.

2. Colorado Medicaid recommends but does not require that documentation follow the Subjective, Objective, Assessment and

Plan (SOAP) format. In addition to the above required information, the visit note should include:

a. A *subjective* element which includes the reason for the visit, the client or caregiver's report of current status relative to treatment goals, and any changes in client's status since the last visit;

b. An *objective* element which includes the practitioner's findings, including abnormal and pertinent normal findings from any procedures or tests performed;

c. An *assessment* component which includes the practitioner's assessment of the client's response to interventions provided, specific progress made toward treatment goals, and any factors affecting the intervention or progression of goals; and

d. A *plan* component which states the plan for next visit(s).

v. Discharge Summary

1. At the conclusion of therapy services, a discharge summary must be included in the documentation of the final visit in an episode of care. This may include the following:

a. Highlights of a client's progress or lack of progress towards treatment goals.

b. Summary of the outcome of services provided during the episode of care.

g. NON-COVERED SERVICES AND GENERAL LIMITATIONS

i. Colorado Medicaid does not cover items and services which generally enhance the personal comfort of the eligible person but are not necessary in the diagnosis of, do not contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member.

ii. Maintenance programs beginning when the therapeutic goals of a treatment plan have been achieved and no further functional progress is apparent or expected to occur, are **not** covered for adult clients.

iii. Services provided without a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law are not covered, unless they are covered by an Individual Family Service Plan (IFSP).

iv. Treatment of speech and language delays not associated with an acquired or chronic medical condition, neurological disorder, acute illness, injury, or congenital defect are not covered, unless they are covered by an Individual Family Service Plan (IFSP).

v. Any service that is not determined by the provider to be medically necessary according to the definition of medical necessity in the Speech Language-Hearing Services Benefit Coverage Standard is not covered.

vi. Hearing aids for adults are not a covered service.

vii. Hearing exams and evaluations are a benefit for adults only when a concurrent medical condition exists.

viii. Initial placement of cochlear implants for adults **is not covered.**

ix. The upgrading of a cochlear implant system or component (e.g., upgrading processor from body worn to behind the ear, upgrading from single to multi-channel electrodes) of an existing properly functioning cochlear implant is not covered.

x. Services not documented in the client's Plan of Care are not covered.

xi. Services specified in a plan of care that is not reviewed and revised as medically necessary by the client's attending physician or by an IFSP are not covered.

xii. Services that are not designed to improve or maintain the functional status of a recipient with a physical loss or a cognitive or psychological deficit are not covered.

xiii. A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements is not covered.

xiv. Vocational or educational services, including functional evaluations, except as provided under IEP-related services are not covered.

xv. Services provided by unsupervised therapy assistants as defined by the American Speech-Language Hearing Association (ASHA) are not covered.

xvi. Treatment for dysfunction that is self-correcting (for example, natural dysfluency or developmental articulation errors) is not covered.

xvii. Psychosocial services are not covered.

xviii. Costs associated with record keeping documentation and travel time are not covered.

xix. Training or consultation provided by an audiologist to an agency, facility, or other institution is not covered.

xx. Therapy that replicates services that are provided concurrently by another type of therapy is not covered. Particularly, occupational therapy which should provide different treatment goals, plans, and therapeutic modalities from speech therapy.

8.200.4 CERTIFIED FAMILY PLANNING CLINICS

8.200.4.A Laboratories at Certified Family Planning Clinics providing services must meet all Clinical Laboratory Improvement Amendment requirements.

8.200.4.B Services at a Certified Family Planning Clinic shall be rendered under the General Supervision of a physician. General Supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

8.200.4.C The Certified Family Planning Clinic shall contact the client's Primary Care Provider or Primary Care Medical Provider or managed care organization, if applicable, prior to rendering services that require a referral.

8.200.5 REIMBURSEMENT

8.200.5.A The amount of reimbursement for physician services is the lower of the following:

1. Submitted charges; or

2. Fee schedule as determined by the Department of Health Care Policy and Financing which may be a manual pricing.

8.200.5.B Reimbursement for services may be made directly to Advanced Practice Nurses, registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, and licensed psychologists unless the non-physician practitioner is acting within the scope of his/her contract with a physician or public or private institution or employment as a salaried employee of a physician or public or private institution.

8.200.5.C Dental hygienists may be directly reimbursed for unsupervised dental hygiene services.

a. Hygienists employed by a dentist, clinic, or institution shall submit claims under the employer's provider identification number.

8.200.5.D The amount of reimbursement for Certified Family Planning Clinic services may be paid directly to the clinic and is the lower of the following:

1. Submitted charges; or

2. Fee schedule as determined by the Department of Health Care Policy and Financing which may be a manual pricing.

8.200.5.E A provider shall not be reimbursed directly for services if the provider is acting as a contract agent or employee of a nursing home, hospital, Federally Qualified Health Center, Rural Health Center, clinic, home health agency, school, or physician.

8.200.5.F A provider shall not be reimbursed for services as a billing provider if the provider is a student in a graduate education program and the facility where the provider delivers services receives Graduate Medical Education payments pursuant to Colorado Revised Statutes Section 25.5-4-402.5 or 10 C.C.R. 2505-10, Sections 8.300.7.

8.200.6 INCREASED MEDICAL PAYMENTS TO PRIMARY CARE PHYSICIANS PROGRAM

The Increased Medical Payments to Primary Care Physicians Program provides reimbursement above the fee schedule to defined and attested primary care physicians for certain services provided in calendar years 2013 and 2014.

8.200.6.A Authority

This rule is made pursuant to title 42 of the Code of Federal Regulations, Section 438.6, Section 438.804, Part 441 Subpart L, and Part 447 Subpart G (2012).

8.200.6.B Definitions

1. Primary Care Physician means a medical doctor who attests to the Department that he or she has a primary specialty designation of family medicine, general internal medicine, or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association.

2. Personal Supervision means the physician accepts professional responsibility and legal liability for the services provided by the non-physician provider. Personal Supervision does not require physical presence at the location of the services.

8.200.6.C Attestation

1. A Primary Care Physician is required to self-identify, using the form available on the www.colorado.gov/hcpf, provider's web page, to a specialty designation of family medicine, general internal medicine or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties or the American Osteopathic Association. A physician must self-attest that he/she:

    a. Is Board certified with such a specialty or subspecialty; and/or

    b. Has furnished evaluation and management services and vaccine administration services under codes described in 8.200.6.E that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

8.200.6.D Reimbursable Services

1. Primary care services with procedure codes listed in 8.200.6.E provided by a Primary Care Physician, as defined in 8.200.6.B.1, are eligible for increased reimbursement.

2. Primary care services with procedure codes listed in 8.200.6.E provided by a Physician Assistant or Advanced Nurse Practitioner under the personal supervision of a Primary Care Physician, as defined in 8.200.6.B.1, are eligible for increased reimbursement.

    a. For this program, when services by a non-physician provider are provided under the personal supervision of a physician, the physician may be identified as the rendering provider on claims.

8.200.6.E Procedure Codes

The procedure codes covered by the Colorado Medical Assistance program designated in the Healthcare Common Procedure Coding System (HCPCS) for increased reimbursement shall be 99201-99499 and Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474.

8.200.6.F Supplemental Payment Procedure

1. Supplemental payments to eligible providers are calculated in the manner defined in 42 C.F.R. part 447.405 and identified in the schedule of maximum payments published on the website of the Department of Health Care Policy and Financing. Title 42 of the Code of Federal Regulations, Part 447.405 (2012) is hereby incorporated by reference into this

rule. Such incorporation, however, excludes later amendments to or additions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203.

2. Supplemental payments will be made on a quarterly basis.

3. The initial supplemental payment will be made after approval of the State Plan Amendment approving the increase.

8.200.6.G Audits

1. Eligible providers shall maintain all increased payment to primary care provider program-related records including documentation to support attestations.

2. Eligible providers shall permit the Department, the federal government, the Medicaid Fraud Control Unit and any other duly authorized agent of a governmental agency:

   a. To audit, inspect, examine, excerpt, copy and/or transcribe the records related to this incentive program, to assure compliance with the program requirements, Corrective Action Plans and attestations.

   b. To access the provider's premises, to inspect and monitor, at all reasonable times, the provider's compliance with program requirements, Corrective Action Plans and attestations. Monitoring includes, but is not limited to, internal evaluation procedures, examination of program data, special analyses, on-site checking, observation of employee procedures and use of electronic health information systems, formal audit examinations, or any other procedure.

3. Eligible providers shall cooperate with the State, the federal government, the Medicaid Fraud Control Unit and any other duly authorized agent of a governmental agency seeking to audit a provider's compliance with program requirements.

4. The Department may recoup by offset from any payment due to the provider any supplemental payment made to the provider for services rendered during the period that the provider did not meet the requirements for attestation in 8.200.6.C or does not have documentation supporting the required attestation. The Department may recoup by offset any improper or overpaid medical services paid to or on behalf of an eligible provider.

8.200.6.H Informal Reconsideration and Appeal

1. A provider may request an informal reconsideration of his or her exclusion from participation in the Increased Medical Payments to Primary Care Providers Program by submitting a written request within 30 days of date of notice that the provider is not eligible to participa te in the program.

2. A provider may request an informal reconsideration of the supplemental payment amount by submitting a written request within 30 days of the receipt of the supplemental payment.

3. The Department shall respond to the request for informal reconsideration with a decision no later than 45 days after receipt of the request.

4. A provider dissatisfied with the Department's decision may appeal the informal reconsideration decision according to the procedures set forth in 10 C.C.R. 2505-10 Section 8.050.3 PROVIDER APPEALS.