DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rates Section Rule Concerning Definitions, Section 8.500.1 Provider Reimbursement, Section 8.500.14
Rule Number: MSB 16-06-21-A
Division / Contact / Phone: Payment Reform / Randie DeHerrera / 6199

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 16-06-21-A, Revision to the Medical Assistance Rates Section Rule Concerning Definitions, Section 8.500.1 Provider Reimbursement, Section 8.500.14
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) 8.500.1, 8.500.14, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text starting at 8.500.1 paragraph 4 through the end of paragraph 4 with the proposed text. Replace the current text starting at 8.500.1 paragraph 40 through the end of paragraph 40 with the proposed text. Replace the current text starting at 8.500.14.F through the end of 8.500.14.F with the proposed text. This rule is effective 11/30/16.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rates Section Rule Concerning Definitions, Section 8.500.1 Provider Reimbursement, Section 8.500.14
Rule Number: MSB 16-06-21-A
Division / Contact / Phone: Payment Reform / Randie DeHerrera / 6199

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 addition to the rule will state reimbursement paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider may receive payments in the aggregate that exceed its actual costs of providing waiver services. The rule change is necessary to ensure compliance with the Department's waiver application with CMS requiring that state and local government providers be reimbursed actual costs and that reimbursement does not exceed costs. This addition was prompted by and the Office of State Auditor's recommendation which identified the non-compliance with our CMS waiver application.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-6-404

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rates Section Rule Concerning Definitions, Section 8.500.1 Provider Reimbursement, Section 8.500.14
Rule Number: MSB 16-06-21-A
Division / Contact / Phone: Payment Reform / Randie DeHerrera / 6199

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 classes of person who will be affected by the proposed rule include state owned Regional Centers providing Home and Community Based Services waiver services for clients with Developmental or Intellectual Disabilities. The Department of Health Care Policy and Financing and Department of Human Services will bear the costs of the proposed rule as DHS is responsible for administration of the Regional Centers and HCPF is responsible for oversight of the Regional Centers.

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

   There are no probable quantitative or qualitative impacts of the proposed rule upon the affected classes of persons.

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

   The Department of Health Care Policy and Financing will be responsible for costs associated with a third party accounting vendor to ensure actual costs are appropriate, necessary, and waiver client related. The cost to the Department for staffing is minimal. The cost to the Department of Human Services in the form of staffing is also minimal.

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

   The cost of inaction is continued non-compliance with the Departments approved waiver application which may result in disallowance of FFP for services.

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

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

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

   There are no alternatives that will achieve the purpose of the proposed rule.

8.500.1 DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL) means basic self care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-DD Waiver or a HCBS Waiver service.

APPLICANT means an individual who is seeking a long term care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

AUDITABLE: means the information represented on the wavier cost report can be verified by reference to adequate documentation as required by generally accepted auditing standards.

CLIENT means an individual who has met long term care (LTC) eligibility requirements, is enrolled in and chooses to receive LTC services, and receives LTC services.

CLIENT REPRESENTATIVE means a person who is designated by the client to act on the client's behalf. A client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the client to speak for or act on the client's behalf.

COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 27-10.5-105, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-101, C.R.S. *et seq*, and provides authorized services and supports to such clients either directly or by purchasing such services and supports from service agencies.

COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing home and community based services and Medicaid state plan benefits including long term home health services and targeted case management.

COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the client.

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

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. § 6000, *et seq.*, shall not apply.

> "Impairment of General Intellectual Functioning" means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (seventy (70) or less assuming a scale with a mean of 100 and a standard deviation of fifteen (15)), as measured by an instrument which is standardized, appropriate to the nature of the

person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. When an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

"Adaptive Behavior Similar to That of a Person With Mental Retardation" means that the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

"Substantial Intellectual Deficits" means an intellectual quotient that is between seventy-one (71) and seventy-five (75) assuming a scale with a mean of one hundred (100) and a standard deviation of fifteen (15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community Based Services for persons with Developmental Disabilities (HCBS-DD) within the Colorado Department of Human Services.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of Medicaid State Plan for Medicaid eligible children up to the age of twenty-one (21).

FAMILY means a relationship as it pertains to the client and is defined as:

A mother, father, brother, sister or any combination,

Extended blood relatives such as grandparent, aunt, uncle, cousin,

An adoptive parent,

One or more individuals to whom legal custody of a client with a developmental disability has been given by a court

A spouse; or,

The client's children.

FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for long term care services as determined by the Department's prescribed instrument.

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long Term Care instrument and medical verification on the Professional Medical Information Page to determine if the client meets the institutional level of care (LOC).

GROUP RESIDENTIAL SERVICES AND SUPPORTS (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) clients receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment as a residential

care facility or residential community home for persons with developmental disabilities and certified by the Operating Agency.

GUARDIAN means an individual at least twenty-one years (21) of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated client pursuant to appointment by a court. Guardianship may include limited, emergency or temporary substitute court appointed guardian but not a guardian ad litem.

Home And Community Based Services (HCBS) Waiver means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR).

INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) means residential habilitation services provided to three (3) or fewer clients in a single residential setting or in a host home setting that does not require licensure by the Colorado Department of Public Health and Environment. IRSS settings are certified by the Operating Agency.

LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the client's spouse.

INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) for which the Department makes Medicaid payment under the Medicaid State Plan.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR) means a publicly or privately operated facility that provides health and habilitation services to a client with mental retardation or related conditions.

LEVEL OF CARE (LOC) means the specified minimum amount of assistance a client must require in order to receive services in an institutional setting under the Medicaid State Plan.

LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR), or home and community based services (HCBS), long term home health services or the program of all-inclusive care for the elderly (PACE), swing bed and hospital back up program (HBU).

MEDICAID ELIGIBILE means an applicant or client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination.

MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

MEDICATION ADMINISTRATION means assisting a client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

NATURAL SUPPORTS means informal relationships that provide assistance and occur in the client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

OPERATING AGENCY means the Department of Human Services, Division for Developmental Disabilities, which manages the operations of the Home and Community Based Services-for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-

Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the Home and Community Based Services-for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

POST ELIGIBILITY TREATMENT OF INCOME (PETI) means the determination of the financial liability of an HCBS Waiver client as defined in 42 CFR 435.217.

PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, the Operating Agency, a State Fiscal Agent or the Case Management Agency.

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client needs institutional level of care.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in 2 CCR 503-1 16.200 *et seq.*, that has received program approval to provide HCBS-DD Waiver services.

PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use, including vehicles for hire.

RELATIVE means a person related to the client by virtue of blood, marriage, adoption or common law marriage.

RETROSPECTIVE REVIEW means the Department or the Operating Agency's review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service.

SERVICE PLAN means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the Department and the Operating Agency's rules set forth in 10 CCR 2505-10 Section 8.400.

STATE AND LOCAL GOVERNMENT HCBS WAIVER PROVIDER: means the state owned and operated agency providing home and community based services (HCBS) to clients enrolled in the HCBS waiver for Persons with Developmental Disabilities.

SUPPORT is any task performed for the client where learning is secondary or incidental to the task itself or an adaptation is provided.

SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

TARGETED CASE MANAGEMENT (TCM) means a Medicaid State Plan benefit for a target population which includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure nonduplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources.

THIRD PARTY RESOURCES means services and supports that a client may receive from a variety of programs and funding sources beyond natural supports or Medicaid. They may include, but are not limited to, community resources, services provided through private insurance, non-profit services and other government programs.

WAIVER SERVICE means optional services defined in the current federally approved waiver documents and do not include Medicaid State Plan benefits.

8.500.14 PROVIDER REIMBURSEMENT

8.500.14.A Providers shall submit claims directly to the Department's Fiscal Agent through the Medicaid Management Information System (MMIS); or through a qualified billing agent enrolled with the Department's Fiscal Agent.

8.500.14.B Provider claims for reimbursement shall be made only when the following conditions are met:

1. Services are provided by a qualified provider as specified in the federally-approved HCBS-DD Waiver,

2. Services have been prior authorized,

3. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the client's service plan, and

4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.14.C Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.

8.500.14.D When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.14.E When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.14.F For private providers ~~Except where otherwise noted,~~ payment is based on a statewide fee schedule. ~~State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the provider bulletin accessed through the Department's fiscal agent's web site.~~

8.500.14.G Reimbursement paid to State or local government HCBS waiver providers differs from the amount paid to private providers of the same service. No public provider may receive payments in the aggregate that exceed its actual costs of providing HCBS waiver services.

1. Reimbursement paid to State and local government HCBS waiver providers shall not exceed actual costs. All State and local HCBS waiver providers must submit an annual cost report for HCBS waiver services.

2. Actual costs will be determined on the basis of the information on the HCBS waiver cost report and obtained by the Department or its designee for the purposes of cost auditing.

a. The costs submitted by the provider for the most recent available final cost report for a 12 month period shall be used to determine the interim rates for the ensuing 12 month period effective July 1 of each year.

i. The interim rate will be calculated as total reported costs divided by total units per HCBS waiver service.

ii. An interim rate shall be determined for each HCBS waiver service provided.

iii. The most recent available final cost report will be used to set the next fiscal year's interim rates.

b. Reimbursement to State and local government HCBS waiver providers shall be adjusted retroactively after the close of each 12 month period.

c. Total costs submitted by the provider shall be reviewed by the Department or its designee and result in a total allowable cost.

d. The Department will determine the total interim payment through the MMIS.

e. The Department will reconcile interim payments to the total allowable and make adjustments to payments as necessary. Interim payments shall be paid through the MMIS.

3. Submission of the HCBS waiver cost report shall occur annually for costs incurred during the prior fiscal year.

a. The cost report for HCBS waiver services must be submitted to the Department annually on October 31 to reflect costs from July 1-June 30.

b. The cost report will determine the final adjustment to payment for the period for which the costs were reported.

c. Reconciliation to align the fiscal year reimbursement with actual fiscal year costs after the close of each fiscal year shall be determined by the Department annually.

e. A State or local government HCBS waiver provider may request an extension of time to submit the cost report. The request for extension shall:

i. Be in writing and shall be submitted to the Department.

ii. Document the reason for failure to comply.

iii. Be submitted no later than ten (10) working days prior to the due date for submission of the cost report.

f. Failure of a State or local government HCBS waiver provider to submit the HCBS waiver cost report by October 31 shall result in the Department withholding all warrants not yet released to the provider as described below:

i. When a State or local government HCBS waiver provider fails to submit a complete and auditable HCBS waiver cost report on time, the HCBS waiver cost report shall be returned to the facility with written notification that it is unacceptable.

1. The State or local government HCBS waiver provider shall have either 30 days from the date of the notice or until the end of the cost report submission period, whichever is later, to submit a corrected HCBS waiver cost report.

2. If the corrected HCBS waiver cost report is still determined to be incomplete or un-auditable, the State or local government HCBS waiver provider shall be given written notification that it shall, at its own expense submit a HCBS waiver cost report prepared by a Certified Public Accountant (CPA). The CPA shall certify that the report is in compliance with all Department rules and shall give an opinion of fairness of presentation of operating results or revenues and expenses.

3. The Department may withhold all warrants not yet released to the provider when the original cost report submission period and 30-day extension have expired and an -auditable HCBS waiver cost report has not been submitted.

ii. If the audit of the HCBS waiver cost report is delayed by the state or local government HCBS waiver provider's lack of cooperation, the effective date for the new rate shall be delayed until the first day of the month in which the audit is completed. Lack of cooperation shall mean failure to provide documents, personnel or other resources within its control and necessary for the completion of the audit.

4. Non-allowable costs for State and local government providers offering HCBS waiver services include:

a. Room and Board;

b. Costs which have been allocated to an ICF/IID;

c. Costs for which there is either no supporting documentation or for which the supporting documentation is not sufficient to validate the costs;

d. Costs for services that are available through the Medicaid State Plan or provided on an HCBS waiver other than the HCBS waiver for Persons with Developmental Disabilities;

e. Costs for services that are not authorized on an approved HCBS waiver for Persons with Developmental Disabilities PAR.

f. Costs for services that are not authorized by the Department as an HCBS waiver service;

g. Costs which are not reasonable, necessary, and client related.

5. Adjustment(s) to the HCBS waiver cost report shall be made by the Department's contract auditor to remove reported costs that are non-allowable.

a. Following the completion of an audit of the cost report the Department or its contract auditor shall notify the affected State or local government HCBS waiver provider of any proposed adjustment(s) to the costs reported on the HCBS waiver cost report and include the basis of the proposed adjustment(s).

b. The provider may submit additional documentation in response to a proposed adjustment. The Department or its contract auditor must receive the additional documentation or other supporting information from the provider within 14 calendar days of the date of the proposed adjustments letter or the documentation will not be considered.

c. The Department may grant a reasonable period, no longer than 30 calendar days, for the provider to submit such documents and information, when necessary and appropriate, given the providers' particular circumstances.

d. The Department or its contract auditor shall complete the audit of the cost report within 30 days of the submission of documentation by the provider.

DO NOT PUBLISH THIS PAGE

Title of Rule: 8.517 Home and Community Based Services for Persons with Spinal Cord Injury
Rule Number: MSB 16-08-19-A
Division / Contact / Phone: LTSS / Samantha Saxe / 303-866-4289

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 16-08-19-A, 8.517 Home and Community Based Services for Persons with Spinal Cord Injury
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) 8.517.11, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text starting at 8.517.11.C.1.b through the end of 8.517.11.C.1.d with the proposed text. This rule is effective 11/30/16.

DO NOT PUBLISH THIS PAGE

Title of Rule: 8.517 Home and Community Based Services for Persons with Spinal Cord Injury
Rule Number: MSB 16-08-19-A
Division / Contact / Phone: LTSS / Samantha Saxe / 303-866-4289

STATEMENT OF BASIS AND PURPOSE

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

   The purpose of this rule change is to modify the Complementary and Integrative Health Service (CIHS) provider qualifications to increase provider capacity, accessibility, and client choice among availible service providers. The provider qualifications were set in 2012 when the waiver was initiated as a pilot program. In 2015-16, CMS approved a 5-year waiver renewal that included changes to the CIHS provider model to increase provider capacity and also eliminate the waiting list for the SCI waiver. The provider qualifications currently require a minimum of 5 years' experience in their licensed field. This rule is proposing that the minimum qualifcations for providers be changhed to 3 years' experience in their licensed field; or 2 years' experience in their licensed field with at least one year of experience working with individuals with a spinal cord injury or other long term physical disability, or education specific to the physiology of spinal cord injuries as it pertains the provider's field of practice. Provider capacity has been a challenge since this waiver's inception. Through our reasearch and stakeholder engagement, we think this proposed modification to provider qualifications strikes a better balance between issues of access and having trained providers.

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 U.S.C. § 1396a and 42 U.S.C. § 1369n.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-6-1301 through 25.5-6-1303, C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: 8.517 Home and Community Based Services for Persons with Spinal Cord Injury
Rule Number: MSB 16-08-19-A
Division / Contact / Phone: LTSS / Samantha Saxe / 303-866-4289

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 primary class of persons who will be affected by the proposed rule change is the current and prospective clients enrolled in the HCBS-SCI waiver who access and benefit from Complementary and Integrative Health Services, which include acupuncture, chiropractic care, and massage therapy. Specifically, these clients will have an increased network of providers to select from, taking into account their personal preferences or relationships with practitioners, accessibility to the provider's service location, the client's schedule, and the goals of their service treatments.

   Secondarily, this rule change will affect the current and prospective practitioners and provider facilities by allowing more provider facilities with more therapists to enroll to better serve the growing waiver population.

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 will have a positive qualitative impact on SCI waiver clients by providing them with greater accessibility and choice of providers. It will also positively impact current providers by allowing them greater opportunity to hire therapists to serve waiver clients; some providers have expressed interest in expanding their availability to include weekends which would greatly increase opportunities for clients to receive services that work with their schedules. This will also impact prospective providers who have expressed interest in enrolling to provide services but do not have sufficient staff who meet the current qualifications to make it worth their while to enroll as a Medicaid provider.

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 proposed rule change is not anticipated to have any budgetary impact. There may be a slight increase in service expenditures to account for clients who have not been receiving frequent services due to provider capacity or accessibility issues.

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

   The proposed rule change is not anticipated to have any budgetary impact. The slight increase in expenditures that may occur are a result of clients having greater access to providers and greater personal choice of providers. All of this would indicate that clients are using the services to improve their health and well-being and remain in their communities.

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

   The proposed rule change is not anticipated to have any budgetary impact. There are no other methods to achieve the purpose of the proposed rule.

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

   There are no other options to modify the provider qualifications for these services. If the qualifications remain the same, these services will continue to face provider capacity and client access challenges.

8.517 HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY WAIVER

8.517.1 DEFINITIONS OF SERVICES PROVIDED

Adult Day Services means services as defined at Section 8.491.

Complementary and Integrative Health Services means services as defined at Section 8.517.11.

Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.

Electronic Monitoring means services as defined at Section 8.488.

Home Modification means services as defined at Section 8.493.

Homemaker Services means services as defined at Section 8.490.

In-Home Support Services means services as defined at Section 8.552.

Non-Medical Transportation means services as defined at Section 8.494.

Personal Care Services means services as defined at Section 8.489.

Respite Care means services as defined at Section 8.492.

8.517.2 GENERAL DEFINITIONS

Acupuncture means the stimulation of anatomical points on the body by penetrating the skin with thin, solid, metallic, single-use needles that are manipulated by the hands or by electrical stimulation for the purpose of bringing about beneficial physiologic and /or psychological changes.

Chiropractic Care means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting alignment and other musculoskeletal problems.

Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.

Complementary and Integrative Health Provider means an individual or agency certified annually by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.Denver Metro Area means the counties of Adams, Arapahoe, Denver, Douglas, and Jefferson.

Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Massage Therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and/or psychological changes.

Medical Director means an individual that is contracted with the Department of Health Care Policy and Financing to provide oversight of the Complementary and Integrative Health Services and the program evaluation.

Spinal Cord Injury means an injury to the spinal cord which is further defined at 8.517.2.1.

8.517.2.1 SPINAL CORD INJURY DEFINITION

A spinal cord injury is limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:

1. Spinal cord injury unspecified
2. Complete lesion of spinal cord
3. Anterior cord syndrome
4. Central cord syndrome
5. Other specified spinal cord injury
6. Lumbar spinal cord injury without spinal bone injury
7. Sacral spinal cord injury without spinal bone injury
8. Cauda equina spinal cord injury without spinal bone injury
9. Multiple sites of spinal cord injury without spinal bone injury
10. Unspecified site of spinal cord injury without spinal bone injury
11. Injury to cervical nerve root
12. Injury to dorsal nerve root
13. Injury to lumbar nerve root
14. Injury to sacral nerve root
15. Injury to brachial plexus
16. Injury to lumbosacral plexus
17. Injury to multiple sites of nerve roots and spinal plexus
18. Injury to unspecified site of nerve roots and spinal plexus
19. Injury to cervical sympathetic nerve excluding shoulder and pelvic girdles
20. Injury to other sympathetic nerve excluding shoulder and pelvic girdles
21. Injury to other specified nerve(s) of trunk excluding shoulder and pelvic girdles
22. Injury to unspecified nerve of trunk excluding shoulder and pelvic girdles

23. Paraplegia

24. Paraplegia, Unspecified

25. Paraplegia, Complete

26. Paraplegia, Incomplete

27. Quadriplegia/Tetraplegia/Incomplete – unspecified

28. Quadriplegia – C1-C4/Complete

29. Quadriplegia – C1-C4/Incomplete

30. Quadriplegia – C5-C7/Complete

31. Quadriplegia – C5-C7/Incomplete

8.517.3 LEGAL BASIS

The Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver is created upon authorization of a waiver of the state-wideness requirement contained in Section 1902(a)(1) of the Social Security Act (42 U.S.C. § 1396a); and the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act (42 U.S.C. § 1396a). Upon approval by the United States Department of Health and Human Services, this waiver is granted under Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n). 42 U.S.C. § § 1396a and 1396n are incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, CO 80203. Additionally, any incorporated material in these rules may be examined at any State depository library. This regulation is adopted pursuant to the authority in Section 25.5-1-301, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Section 24-4-101 et seq., C.R.S. and the Colorado Medical Assistance Act, Sections 25.5-6-1301 et seq., C.R.S.

The addition of “individual” to the Complementary and Integrative Health Provider definition in section 8.517.2, the addition of hospital level of care eligibility criteria in section 8.517.5.C, the elimination of the waitlist at section 8.517.6.1, the addition of the client’s residence as a service location at section 8.517.11.B.3 and all Medical Director responsibilities are contingent and shall not be in effect until the HCBS-SCI Waiver Renewal CO.0961.R01.00 has been approved by the Centers for Medicare and Medicaid Services (CMS).

8.517.4 SCOPE AND PURPOSE

8.517.4.A. The Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver provides assistance to individuals with spinal cord injuries in the Denver Metro Area that require long term supports and services in order to remain in a community setting.

8.517.4.B. The HCBS-SCI waiver provides an opportunity to study the effectiveness of Complementary and Integrative Health Services and the impact the provision of these service may have on the utilization of other HCBS-SCI waiver and/or acute care services.

8.517.4.C. An independent evaluation shall be conducted no later than January 1, 2020 to determine the effectiveness of the Complementary and Integrative Health Services.

8.517.5 CLIENT ELIGIBILITY

8.517.5.A. ELIGIBLE PERSONS

Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services shall be offered only to individuals who meet all of the following eligibility requirements:

1. Individuals shall be aged 18 years or older.

2. Individuals shall have a diagnosis of Spinal Cord Injury. This diagnosis must be outlined in 8.517.2.1 and documented on the individual's Professional Medical Information Page (PMIP) and in the Uniform Long Term Care 100.2 (ULTC 100.2) assessment tool.

3. Individuals shall have been determined to have a significant functional impairment as evidenced by a comprehensive functional assessment using the ULTC 100.2 assessment tool that results in at least the minimum scores required per Section 8.401.1.15.

4. Individuals shall reside in the Denver Metro Area as evidenced by residence in one of the following counties:

    a. Adams;

    b. Arapahoe;

    c. Denver;

    d. Douglas; or

    e. Jefferson

8.517.5.B FINANCIAL ELIGIBILITY

Individuals must meet the financial eligibility requirements specified at Section 8.100.7 LONG TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.

8.517.5.C LEVEL OF CARE CRITERIA

Individuals shall require long term support services at a level of care comparable to services typically provided in a nursing facility or hospital.

8.517.5.D NEED FOR HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY (HCBS-SCI) WAIVER SERVICES

1. Only individuals that currently receive Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services, or that have agreed to accept HCBS-SCI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-SCI waiver.

    a. Case management is not an HCBS-SCI service and shall not be used to satisfy this requirement.

b. The desire or need for any Medicaid services other than HCBS-SCI waiver services, as listed at Section 8.517.1, shall not satisfy this eligibility requirement.

2. Individuals that have not received at least one (1) HCBS-SCI waiver service for a period greater than 30 consecutive days shall be discontinued from the waiver.

8.517.5.E EXCLUSIONS

1. Individuals who are residents of nursing facilities or hospitals are not eligible to receive Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services.

2. HCBS-SCI clients that enter a nursing facility or hospital may not receive HCBS-SCI waiver services while admitted to the nursing facility or hospital.

a. HCBS-SCI clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-SCI program.

b. HCBS-SCI clients entering a nursing facility for Respite Care as an HCBS-SCI service shall not be discontinued from the HCBS-SCI program.

8.517.5.F COST CONTAINMENT AND SERVICE ADEQUACY

1. Individuals shall not be eligible for the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver if the case manager determines any of the following during the initial assessment and service planning process:

a. The individual's needs cannot be met within the Individual Cost Containment Amount.

b. The individual's needs are more extensive than HCBS-SCI waiver services are able to support and/or that the individual's health and safety cannot be assured in a community setting.

2. Individuals shall not be eligible for the HCBS-SCI waiver at reassessment if the case manager determines the individual's needs are more extensive than HCBS-SCI waiver services are able to support and/or that the individual's health and safety cannot be assured in a community setting.

3. Individuals may be eligible for the HCBS-SCI waiver at reassessment if the case manager determines that HCBS-SCI waiver services are able to support the individual's needs and the individual's health and safety can be assured in a community setting.

a. If the case manager expects that the services required to support the individual's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the service plan to determine if the individual's request for services is appropriate and justifiable based on the individual's condition.

i) Individuals may request of the case manager that existing services remain intact during this review process.

ii) In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:

1) The client's appeal rights pursuant to Section 8.057; and

2) Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.

8.517.6 WAITING LIST

1. The number of clients who may be served through the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver during a fiscal year may be limited by the federally approved waiver.

2. Individuals determined eligible for the HCBS-SCI waiver who cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

3. The waiting list shall be maintained by the Department.

4. The case manager shall ensure the individual meets all eligibility criteria as set forth at Section 8.517.5 prior to notifying the Department to place the individual on the waiting list.

5. The date the case manager determines an individual has met all eligibility requirements as set forth at Section 8.517.5 is the date the Department will use for the individual's placement on the waiting list.

6. When an eligible individual is placed on the waiting list for the HCBS- SCI waiver, the case manager shall provide a written notice of the action in accordance with section 8.057 et seq.

7. As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for the HCBS-SCI waiver in the order of the individual's placement on the waiting list

8. When an opening for the HCBS-SCI waiver becomes available the Department will provide written notice to the Case Management Agency.

9. Within ten business days of notification from the Department that an opening for the HCBS-SCI waiver is available the Case Management Agency shall:

   a. Reassess the individual for functional level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.

   b. Update the existing functional level of care assessment in the official client record if less than six months has elapsed since the date of the previous assessment.

   c. Reassess for eligibility criteria as set forth at 8.517.5.

   d. Notify the Department of the individual's eligibility status.

8.517.7 START DATE FOR SERVICES

8.517.7.A. The start date of eligibility for Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services shall not precede the date that all of the

requirements at Section 8.517.5, have been met. The first date for which HCBS-SCI waiver services may be reimbursed shall be the later of the following:

1. The date at which financial eligibility is effective.

2. The date at which the level of care and targeting criteria are certified.

3. The date at which the individual agrees to accept services and signs all necessary intake and service planning forms.

4. The date of discharge from the hospital or nursing facility.

8.517.8 CASE MANAGEMENT FUNCTIONS

8.517.8.A. The requirements at Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver.

8.517.9 PRIOR AUTHORIZATION OF SERVICES

8.517.9.A. All Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services must be prior authorized by the Department or its agent.

8.517.9.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.517.9.C. Claims for services are not reimbursable if:

1. Services are not consistent with the client’s documented medical condition and functional capacity;

2. Services are not medically necessary or are not reasonable in amount, scope, frequency, and duration;

3. Services are duplicative of other services included in the client’s Service Plan;

4. The client is receiving funds to purchase services; or

5. Services total more than 24 hours per day of care.

8.517.9.D. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.

8.517.9.E. Payment for HCBS-SCI waiver services is also conditional upon:

a. The client's eligibility for HCBS-SCI waiver services;

b. The provider’s certification status; and

c. The submission of claims in accordance with proper billing procedures.

8.517.9.F. Prior authorization of services is not a guarantee of payment. All services must be provided in accordance with regulation and necessary to meet the client's needs.

8.517.9.G. Services requested on the PAR shall be supported by information on the Long Term Care Service Plan, the ULTC-100.2, and written documentation from the income maintenance technician of the client's current monthly income.

8.517.9.H. The PAR start date shall not precede the start date of HCBS-SCI eligibility in accordance with Section 8.517.7.

8.517.9.I. The PAR end date shall not exceed the end date of the HCBS-SCI eligibility certification period.

8.517.10 PROVIDER AGENCIES

8.517.10.A. HCBS-SCI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.

8.517.11 COMPLEMENTARY AND INTEGRATIVE HEALTH SERVICES

Complementary and Integrative Health Services are limited to Acupuncture, Chiropractic Care, and Massage Therapy as defined at Section 8.517.2.

8.517.11.A. Inclusions

1. Acupuncture used for the treatment of conditions or symptoms related to the client's spinal cord injury.

2. Chiropractic Care used for the treatment of conditions or symptoms related to the client's spinal cord injury.

3. Massage Therapy used for the treatment of conditions or symptoms related to the client's spinal cord injury.

8.517.11.B. Exclusions / Limitations

1. Complementary and Integrative Health Services shall be provided only for the treatment of conditions or symptoms related to the client's spinal cord injury.

2. Complementary and Integrative Health Services shall be limited to the client's assessed need for services as determined by the Complementary and Integrative Health Provider and documented in the Complementary and Integrative Health Care Plan.

3. Complementary and Integrative Health Services shall be provided in an approved outpatient setting in accordance with 8.517.11.C.2 or in the client's residence.

4. Complementary and Integrative Health Services shall be provided only by a Complementary and Integrative Health Provider certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.

5. Clients receiving Complementary and Integrative Health Services shall participate in an independent evaluation to determine the effectiveness of the services.

6. The Complementary and Integrative Health Services benefit is limited as follows:

    a. A client may receive each of the three individual Complementary and Integrative Health Services on a single date of service.

b. A client shall not receive more than four (4) units of each individual Complementary and Integrative Health Service on a single date of service.

c. A client shall not receive more than 204 units of a single Complementary and Integrative Health service during a 365 day certification period.

d. A client shall not receive more than 408 combined units of all Complementary and Integrative Health Services during a 365 day certification period.

8.517.11.C. Certification Standards

1. Organization and Staffing

a. Complementary and Integrative Health Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice.

b. Acupuncturists shall be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Acupuncturists Practice Act (12-29.5-101, C.R.S.) and have at least ~~five~~ three (3) years' experience practicing Acupuncture at a rate of 520 hours per year; or at least two (2) years' experience practicing acupuncture at a rate of 520 hours per year AND at least one (1) year of experience working with individuals with spinal cord injuries or other long term physical disabilities, or education specific to the physiology of spinal cord injuries as it pertains to the treatment of using acupuncture. ~~at a rate of at least 750 hours per year.~~

c. Chiropractors shall be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (12-33-101, C.R.S.) and have at least ~~five~~ three (3) years' experience practicing Chiropractic Care at a rate of 520 hours per year; or at least two (2) years' experience practicing Chiropractic Care at a rate of 520 hours per year AND at least one (1) year of experience working with individuals with spinal cord injuries or other long term physical disabilities, or education specific to the physiology of spinal cord injuries as it pertains to the treatment of using chiropractic care. ~~at a rate of at least 750 hours per year.~~

d. Massage Therapists shall be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (12-35.3-101, C.R.S.) and have at least ~~five~~ three (3) years' experience practicing Massage Therapy at a rate of 520 hours per year; or at least two (2) years' experience practicing massage therapy at a rate of 520 hours per year AND at least (1) year of experience working with individuals with spinal cord injuries or other long term physical disabilities, or education specific to the physiology of spinal cord injuries as it pertains to the treatment of using massage therapy. ~~at a rate of at least 750 hours per year.~~

2. Environmental Standards for Complementary and Integrative Health Services provided in an outpatient setting.

a. Complementary and Integrative Health Providers shall develop a plan for infection control that is adequate to avoid the sources of and prevent the transmission of infections and communicable diseases. They shall also develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Sterilization procedures shall be developed and implemented in necessary service areas.

b. Policies shall be developed and procedures implemented for the effective control of insects, rodents, and other pests.

c. All wastes shall be disposed in compliance with local, state and federal laws.

d. A preventive maintenance program to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe and sanitary operating condition shall be provided. Emergency Systems, and all essential equipment and supplies shall be inspected and maintained on a frequent or as needed basis.

e. Housekeeping services to ensure that the premises are clean and orderly at all times shall be provided and maintained. Appropriate janitorial storage shall be maintained.

f. Outpatient settings shall be constructed and maintained to ensure access and safety.

g. Outpatient settings shall demonstrate compliance with the building and fire safety requirements of local governments and other state agencies.

3. Failure to comply with the requirements of this rule may result in the revocation of the Complementary and Integrative Health Provider certification.

8.517.11.D COMPLEMENTARY AND INTEGRATIVE HEALTH CARE PLAN

1. Complementary and Integrative Health Providers shall:

a. Guide the development of the Complementary and Integrative Health Care Plan in coordination with the client and/or client's representative.

b. Recommend the appropriate modality, amount, scope, and duration of the Complementary and Integrative Health Services within the established limits as listed at 8.517.11.B;

c. Recommend only services that are necessary and appropriate and will be rendered by the recommending Complementary and Integrative Health Provider.

2. The Complementary and Integrative Health Provider shall reassess the Complementary and Integrative Health Care Plan at least annually or more frequently as necessary. The reassessment shall include a visit with the client.

3. When recommending the use of Complementary and Integrative Health Services for the treatment of a condition or symptom related to the client's spinal cord injury, the Complementary and Integrative Health Provider should use evidence from published medical literature that demonstrates the effectiveness of the services for the treatment of the condition or symptom.

a. Where no evidence exists, the Complementary and Integrative Health Provider shall use their field expertise to guide service recommendations.

b. If additional expertise is required the Complementary and Integrative Health Provider may; consult the Medical Director and/or consult other Complementary and Integrative Health service providers.

4. The Complementary and Integrative Health Care Plan shall be developed using Department prescribed form(s) or template(s).

6. The Complementary and Integrative Health Care Plan shall include at least the following:

a. A summary of the client's treatment history;

b. An assessment of the client's current medical conditions/needs.

c. The amount, scope, and duration of each recommended Complementary and Integrative Health Services and the expected outcomes.

d. The recommended schedule of services.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960.
Rule Number: MSB 16-05-19-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 16-05-19-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:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text starting at 8.960.1 through th end of 8.960.1 with the proposed text. Replace the current text starting at 8.960.3.E.3 through the end of 8.960.3.E.3 with the proposed text. Replace the current text starting at Appendix A through the end of Appendix A with the proposed text. This rule is effective 11/30/16.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960.
Rule Number: MSB 16-05-19-A
Division / Contact / Phone: Special Financing / Chandra Vital / 303-866-5506

STATEMENT OF BASIS AND PURPOSE

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

   This rule change incorporates immediate dentures, partial denture made with cast metal framework with resin denture bases, removal of torus palatinus/mandibularis, and denture program payments into Appendix A.

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)

DO NOT PUBLISH THIS PAGE

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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 incorporates immediate dentures, partial dentures made with cast metal framework with resin denture bases, removal of torus palatinus/mamdibularis, and denture program payment changes into Appendix A. These additions will add an extra benefit for eligible seniors. The only cost the eligible seniors will have is the Max Patient Co-pay listed on Appendix A.

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

   The incorporation of the immediate dentures, partial dentures made with cast metal framework with resin denture bases copayments will be the same as existing complete and partial dentures. The incorporation of the removal of torus palatinus/mandivularis will have the same max co-pay as other oral and maxillofacial surgeries listed in Appendix A. Therefore, there is no change in cost or economic impact on eligible seniors.

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

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

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

   The incorporation of the immediate dentures allows the eligible seniors to maintain healthy eating after tooth extraction. The partial dentures made with cast metal framework with resin denture bases is more durable than the current flexible resin base partial dentures. The incorporation of the removal of torus

palatinus/mandibularis will offer a solution if the torus palatinus/mandibularis causes a problem in the placement of dentures or dental prosthesis.

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

   This rule change is necessary to incorporate these valuable services to the eligible seniors.

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

   This rule change is necessary to incorporate the immediate dentures, partial dentures made with cast metal framework with resin denture bases, and the removal of torus palatinus/mandibularis into Appendix A. 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.

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 or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is able to demonstrate lawful presence in the statecountry 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. An Eeligible sSenior shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective August 30, 2016), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

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

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

Evaluation means an ~~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).

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~~ Client Co-Pay.

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

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

Restorative Services means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic ~~requirements~~ needs 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 Appendix A, and any other information required by the Department.

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

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

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

8.960.3.F Annual Report

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

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

1. The number of Eligible Seniors served;

2. The types of Covered Dental Care Services provided;

3. An itemization of administrative expenditures; and

4. Any other information deemed relevant by the Department.

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

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

Procedure Description	**Alpha-numeric Code**	**Max Allowable Fee**	**Program Payment**	**Max ~~Patient~~ Client Co-Pay**	**PROGRAM GUIDELINES**
Periodic oral evaluation - established ~~patient~~client	D0120	$46.00	$46.00	$0.00	Evaluation performed on a ~~patient~~ client of record to determine any changes in the client's ~~medical or~~ dental and medical health status since a previous comprehensive or periodic ~~last~~ evaluation. This may ~~I~~include~~s~~ an oral cancer evaluation and ~~,~~ periodontal evaluation, diagnosis, treatment planning. Frequency: One time per 6 month period per ~~patient~~client~~; 2 week window accepted~~.
Limited o~~O~~ral e~~E~~valuation - problem f~~F~~ocused	D0140	$62.00	$52.00	$10.00	Evaluation limited to a specific oral health problem or complaint. This code must be used in association with ~~/~~a specific oral health problem or complaint and is not to be used to address situations that arise during multi-visit treatments covered by a single fee, such as, endodontic or post-operative visits related to treatments including prosthesis. Specific problems may include dental emergencies, trauma, acute infections, etc. ~~Should~~ Cannot be used for adjustments made to prosthesis provided within

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					previous 6~~12~~ months. ~~Should~~ Cannot be used as an encounter fee.
Comprehensive o~~O~~ral e~~E~~valuation - new or established ~~patient~~client	D0150	$81.00	$81.00	$0.00	Evaluation used by general dentist or a specialist when evaluating a client comprehensively. Applicable to new ~~patients~~clients; ~~or~~ established ~~patients~~ clients with~~/~~ significant health changes~~,~~ or other unusual circumstances; or established clients who have been ~~absence~~ absent from active treatment for three or more ~~than 5~~ years. ~~This~~It ~~includes~~is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, and an evaluation and recording of the ~~patient's~~ client's dental and medical history and general health assessment. A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included. Frequency: 1 per ~~5~~ 3 years per ~~patient~~client. ~~Should~~ Cannot be charged on the same date as D0180.
Comprehensive p~~P~~eriodontal e~~E~~valuation - new or	D0180	$88.00	$88.00	$0.00	Evaluation for ~~patients~~ clients presenting signs & symptoms of periodontal disease & ~~patients~~ clients with ~~/~~risk factors such as

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
established ~~patient~~client					smoking or diabetes. It includes evaluation of ~~This evaluation encompasses a comprehensive oral exam, and full, complete & detailed~~ periodontal conditions, probing and charting, evaluation and recording of the client's dental and medical history and general health assessment. ~~It may include the evaluation and recording of the patient's dental and medical history and general health assessment.~~ It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. Frequency: 1 per 3 years per ~~patient~~client. ~~Should~~ Cannot 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, usually consisting of 14~~6~~-22 periapical & posterior bitewing images intended to display~~ing~~ 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 with~~/~~in 60 days of a full month series or

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					a panoramic film is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per ~~patient~~client. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 ~~should~~ must be billed and reimbursed as D0210. Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.
Intraoral - periapical first radiographic image	D0220	$25.00	$25.00	$0.00	D0220 one (1) per day per ~~patient~~client. 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~~ must 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. D0210 will only be reimbursed every 5 years.

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
Panoramic radiographic image	D0330	$63.00	$63.00	$0.00	Frequency: 1 per 5 years per ~~patient~~client. ~~Should~~ Cannot be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 years.
Prophylaxis - a~~A~~dult	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 with~~/~~ D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth not receiving nonsurgical ~~periodental~~periodontal therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					D1110 ~~should~~ can only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed. • ~~Should~~May ~~not~~ be alternated w/D4910 for maintenance of periodontally-involved individuals. ~~Should~~ Cannot 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 appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. ~~Should~~ Cannot be used with D1208.
Topical application of fluoride - excluding varnish	D1208	$52.00	$52.00	$0.00	Any fluoride application, including swishing, trays or paint on variety, to be used in conjunction ~~w/prophylaxis~~with prophylaxis or preventive appointment. Frequency: one (1) time per 12 calendar months. ~~Should~~ Cannot be used with D1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
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. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - two surfaces, primary or permanent	D2150	$138.00	$128.00	$10.00	Includes tooth preparation, all adhesives, liners, ~~etching,~~ polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
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. See Explanation of Restorations.
Amalgam - four or more surfaces, primary or permanent	D2161	$203.00	$193.00	$10.00	Includes tooth preparation, all adhesives, liners, ~~etching,~~ polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, anterior	D2330	$115.00	$105.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, ~~polishing,~~ and bases. Adjustments are included. See Explanation of Restorations.
Resin-based composite - two surfaces, anterior	D2331	$146.00	$136.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, ~~polishing,~~ and bases.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	$179.00	$169.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, ~~polishing,~~ and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	$212.00	$202.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, ~~polishing,~~ and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, posterior	D2391	$134.00	$124.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, ~~polishing,~~ and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite -two surfaces, posterior	D2392	$176.00	$166.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, ~~polishing,~~ and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	$218.00	$208.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, ~~polishing,~~ and bases. Adjustments are included.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces, posterior	D2394	$268.00	$258.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, ~~polishing,~~ and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Crown - porcelain/ceramic substrate	D2740	$780.00	$730.00	$50.00	Only ~~O~~one of the following will be reimbursed each 84 months per client per tooth: ~~(D2710, D2712, D2721, D2722,~~ D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or 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	Only ~~O~~one of the following will be reimbursed each 84 months per client per tooth: ~~(D2710, D2712, D2721, D2722,~~ D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or 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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					posterior teeth in occlusion.
Crown - porcelain fused to predominantly base metal	D2751	$780.00	$730.00	$50.00	Only ~~O~~one of the following will be reimbursed each 84 months per client per tooth: ~~(D2710, D2712, D2721, D2722,~~ D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or 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	Only ~~O~~one the following will be reimbursed each 84 months per client per tooth~~of~~: ~~(D2710, D2712, D2721, D2722,~~ D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or 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 predominantly base metal	D2781	$780.00	$730.00	$50.00	Only ~~O~~one of the following will be reimbursed each 84 months per client per tooth: ~~(D2710, D2712, D2721, D2722,~~ D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794~~) per 84~~

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					~~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	Only ~~O~~one of the following will be reimbursed each 84 months per client per tooth: ~~(D2710, D2712, D2721, D2722,~~ D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or 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	Only ~~O~~one of the following will be reimbursed each 84 months per client per tooth: ~~(D2710, D2712, D2721, D2722,~~ D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or 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	Only ~~O~~one of the following will be reimbursed each 84 months per client per tooth: ~~(D2710, D2712, D2721, D2722,~~ D2740,

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or 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	Only ~~O~~one of the following will be reimbursed each 84 months per client per tooth: ~~(D2710, D2712, D2721, D2722,~~ D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or 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	Only ~~O~~one of the following will be reimbursed each 84 months per client per tooth: ~~(D2710, D2712, D2721, D2722,~~ D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or 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~~ Client Co-Pay	PROGRAM GUIDELINES
Crown - titanium	D2794	$780.00	$730.00	$50.00	Only ~~O~~one of the following will be reimbursed each 84 months per client per tooth: ~~(D2710, D2712, D2721, D2722,~~ D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or 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.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	$87.00	$77.00	$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	$89.00	$79.00	$10.00	Not allowed within 6 months of placement.
Core buildup, including any pins when required	D2950	$225.00	$200.00	$25.00	Only ~~O~~one of the following will be reimbursed per 84 months per client per tooth. ~~(~~D2950, D2952, or D2954~~) per 84 month(s) per patient per tooth~~. Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. ~~anatomical crown when restorative crown will be placed.~~ Not payable on the same tooth

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					and same day as D2951.
Pin r~~R~~etention per tooth	D2951	$50.00	$40.00	$10.00	Pins placed to aid in retention of restoration. ~~Should~~ Can only be used in combination with a multi-surface amalgam.
Cast post and core in addition to crown	D2952	$332.00	$307.00	$25.00	Only ~~O~~one of the following will be reimbursed per 84 months per client per tooth. ~~(~~D2950, D2952, or 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	Only ~~O~~one of the following will be reimbursed per 84 months per client per tooth. ~~(~~D2950, D2952, or D2954~~) per 84 month(s) per patient per tooth~~. Core is built around a prefabricated post. This procedure includes the core material and ~~R~~refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	$566.40	$516.40	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					Teeth covered: ~~–~~6-11~~,~~ and 22-27.
Endodontic therapy, bicuspid tooth (excluding final restoration)	D3320	$661.65	$611.65	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: ~~–~~4, 5, 12, 13, 20, 21, 28, and 29.
Endodontic therapy, molar (excluding final restoration)	D3330	$786.31	$736.31	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: ~~–~~2, 3, 14, 15, 18, 19, 30, and 31.
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~~ clients with~~/~~ periodontal disease and is therapeutic, not prophylactic. D4341 and D1110 can be reported on same service date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 ~~may~~ can only be charged

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					once, not per quadrant~~.~~; A diagnosis of periodontitis with~~/~~ clinical attachment loss (CAL) included. Diagnosis and classification of the periodontology case type must be in accordance with~~/~~ documentation as currently established by the American Academy of Periodontology. Current periodontal charting must be present in ~~patient~~ client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than ~~When 4~~2 quadrants may ~~are~~be considered ~~completed~~ in a single visit in a non-hospital setting.~~,~~ ~~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 a~~Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	$128.00	$128.00	$0.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For ~~patients~~ clients with~~/~~ periodontal disease and is therapeutic, not prophylactic. D4342~~1~~ 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~~ can only be charged once, not per quadrant~~.~~; A diagnosis of periodontitis with~~/~~ clinical attachment loss (CAL) included. Current periodontal charting must be present in ~~patient~~ client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • ~~When 4~~No more than 2 quadrants may be ~~are completed~~ considered in a single visit in a non-hospital setting.~~,~~ ~~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 a~~Any

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					follow-up and re-evaluation are included in the initial reimbursement.
Periodontal maintenance procedures	D4910	$136.00	$136.00	$0.00	Procedure following periodontal therapy ~~(~~D4341 or ~~,~~D4342~~)~~. This procedure includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root pla~~n~~ning where indicated and polishing the teeth. ~~If D1110 is once again reported then scaling and root planing will be required to use D4910.~~ Frequency: • ~~u~~Up to four ~~(4)~~ times per fiscal year per ~~patient~~client. ~~Should not be charged alternating with D1110.~~ • Cannot be charged w~~/~~ith in the first three months following active periodontal treatment.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
Complete denture - maxillary	D5110	$793.00	$713.00	$80.00	Reimbursement made upon ~~DELIVERY~~ delivery of a ~~(~~complete~~d)~~ maxillary denture to the client. D5110 or D5120 ~~should~~ cannot be used to report an immediate denture~~.~~ ~~Immediate denture,~~ ~~(~~D5130 or~~,~~ 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~~/~~ith in ~~12~~6 months ~~should~~ are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon ~~patient~~client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years ~~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~~ Client Co-Pay	PROGRAM GUIDELINES
					documentation that existing prosthesis cannot be made serviceable ~~should~~ must be maintained.
Complete denture - mandibular	D5120	$793.00	$713.00	$80.00	Reimbursement made upon ~~DELIVERY~~ delivery of a ~~(~~complete~~d)~~ mandibular denture to the client. D5110 or D5120 ~~should~~ cannot 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 with~~/~~in 6~~12~~ months ~~should~~ are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					greatly depending upon ~~patient~~client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years~~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~~ must be maintained.
Immediate denture – maxillary	D5130	$793.00	$713.00	$80.00	Reimbursement made upon delivery of an immediate maxillary denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5130 can be reimbursed only once per lifetime per client. Complete denture, D5110, may be considered 5 years after immediate denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – mandibular	D5140	$793.00	$713.00	$80.00	Reimbursement made upon delivery of an immediate mandibular denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5140 can be reimbursed only once per lifetime per client. Complete dentures, D5120, may be considered 5 years after immediate denture was reimbursed – documentation that existing prosthesis cannot be made serviceable must be maintained.
Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	D5211	$700.00	$640.00	$60.00	Reimbursement made upon ~~DELIVERY~~ delivery of a ~~(~~complet~~eion) of~~ partial maxillary denture to the client. ~~D5211 or D5212 should not be used to report an interim partial denture (D5820, D5821).~~ D5211 and D5212 ~~should be~~are considered definitive treatments. Routine follow-up adjustments or relines within 6~~12~~ months ~~should~~ are to be anticipated and are included in the initial reimbursement. A partial resin

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin maxillary per every 3 years~~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~~ must 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~~ delivery of a ~~(~~complete ~~ion) of~~ partial mandibular denture to the client. ~~D5211 or D5212 should not be used to report an interim partial denture (D5820, D5821).~~ D5211 and D5212 ~~should~~ are~~be~~ considered definitive treatment. Routine follow-up adjustments/relines within 6~~12~~ months ~~should~~ are to be anticipated and are included in

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin mandibular per every 3 years ~~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~~ must be maintained.
Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213	$778.00	$718.00	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can also be made right after having teeth extracted (healing from only a few teeth is not as extensive as

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.
Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	$778.00	$718.00	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every five years - documentation that existing prosthesis cannot be made

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					serviceable must be maintained.
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	D5221	$509.00	$449.00	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5221 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	D5222	$509.00	$449.00	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5222 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and	D5223	$778.00	$718.00	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5223 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
teeth)					be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5224	$778.00	$718.00	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5224 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.
Repair b~~*B~~roken complete denture base	D5510	$87.00	$77.00	$20.00	Repair b~~*B~~roken complete denture base.
Replace missing or b~~*B~~roken teeth - complete denture (each tooth)	D5520	$73.00	$63.00	$10.00	Replacement/repair of missing or b~~*B~~roken teeth.
Repair resin denture base	D5610	$95.00	$85.00	$10.00	Repair of upper/lower partial denture base.
Repair or replace b~~*B~~roken clasp	D5630	$123.00	$113.00	$10.00	Repair of b~~*B~~roken clasp on partial denture base – per tooth.
Replace b~~*B~~roken 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 – per tooth. Documentation may be requested when charged on partial delivered in last 12 months.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
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~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in addition to a reline in a 12 month period.
Rebase complete mandibular denture	D5711	$322~~08~~.00	$297~~83~~.00	$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in addition to a reline in a 12 month period.
Rebase maxillary partial denture	D5720	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in addition to a reline in a 12 month period.
Rebase mandibular partial denture	D5721	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					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 with~~/~~out processing denture base. Frequency: One (1) time per 12 months. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (chairside)	D5731	$182.00	$172.00	$10.00	Chair side reline that resurfaces with~~/~~out processing denture base. Frequency: One (1) time per 12 months. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (chairside)	D5740	$167.00	$157.00	$10.00	Chair side reline that resurfaces with~~/~~out processing partial denture base. Frequency: one (1) time per 12 months. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot 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 with~~/~~out processing partial denture base. Frequency: one (1) time per 12 months. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in addition to a rebase in a 12

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
					month period.
Reline complete maxillary denture (laboratory)	D5750	$243.00	$218.00	$25.00	Laboratory reline that resurfaces with~~/~~ processing denture base. Frequency: one (1) time per 12 months. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (laboratory)	D5751	$243.00	$218.00	$25.00	Laboratory reline that resurfaces with~~/~~ processing denture base. Frequency: one (1) time per 12 months. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (laboratory)	D5760	$239.00	$214.00	$25.00	Laboratory reline that resurfaces with processing partial denture base. Frequency: one (1) time per 12 months. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (laboratory)	D5761	$239.00	$214.00	$25.00	Laboratory reline that resurfaces with~~/~~ processing partial denture base. Frequency: one (1) time per 12 months. ~~May~~ Cannot be charged on denture provided in the last 6~~12~~ months. ~~May~~ Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
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 an ~~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~~ Can only be charged once per tooth. ~~May~~ Cannot be charged for removal of broken off roots for recently extracted tooth.
Incisional biopsy of oral tissue-soft	D7286	$381.00	$381.00	$0.00	Removing tissue for histologic evaluation. Treatment notes must include documentation and proof that biopsy was sent for evaluation.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
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.
Removal of torus palatinus	D7472	$308.00	$298.00	$10.00	To r~~R~~emove a malformation of bone for proper prosthesis fabrication.
Removal of torus mandibularis	D7473	$300.00	$290.00	$10.00	To r~~R~~emove a malformation of bone for proper prosthesis fabrication.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max ~~Patient~~ Client Co-Pay	PROGRAM GUIDELINES
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins.
Palliative (emergency) treatment of dental pain - minor procedure	D9110	$61.00	$36.00	$25.00	Emergency treatment to alleviate pain/discomfort. This code ~~should~~ cannot be used for filinge claims ~~f~~or writing or calling in a prescription to the pharmacy or to address situations that arise during multi-visit treatments covered by a single fee such as surgical or endodontic treatment. Report per visit, no procedure. Frequency: Limit 1 time per year. Maintain documentation that specifies problem and treatment.

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

Posterior	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial-Occlusal.
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual-Occlusal-Distal.
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Occlusal-Lingual-Distal.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Special Financing Division Colorado Indigent Care Program Rule Concerning Halfway House Residents, Section 8.904F
Rule Number: MSB 16-07-18-A
Division / Contact / Phone: Special Financing / Taryn Jorgensen / 303-866-5634

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 16-07-18-A, Revision to the Special Financing Division Colorado Indigent Care Program Rule Concerning Halfway House Residents, Section 8.904F
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) 8.904F, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	9/9/2016
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text beginning at 8.904F.1.b through the end of 8.904.F.1.b with the new text provided. This revision is effective 11/30/2016.

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Title of Rule: Revision to the Special Financing Division Colorado Indigent Care Program Rule Concerning Halfway House Residents, Section 8.904F
Rule Number: MSB 16-07-18-A
Division / Contact / Phone: Special Financing / Taryn Jorgensen / 303-866-5634

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).

   New Centers for Medicare and Medicaid Services (CMS) guidance (SHO #16-007 dated April 28, 2016) on Federal Financial Participation for people residing in community correctional facilities (halfway houses) has caused Colorado Medicaid to change its policy and allow this population to qualify for Medicaid. Since the Colorado Indigent Care Program (CICP) is a safety net program, the CICP's rules must be updated to coincide with this policy change. Access to health care for this population is in the best interests of the public welfare.

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:

   Emergency rule-making is imperatively necessary in order for the Colorado Indigent Care Program (CICP) to implement changes to coincide with new Medicaid policy regarding Colorado residents residing in halfway houses who have freedom of movement and association becoming eligible for Medicaid. The people within this population who do not qualify for Medicaid due to being over income or who are legal immigrants who have not been in the country for more than five years would instead be eligible for the Colorado Indigent Care Program's dicount health care services under the new rule. Access to health care for this population is a matter of public welfare. Immediate action is required to allow access to discounted health care services. Denying them access would cause unnecessary risks associated with delayed care.

3. Federal authority for the Rule, if any:

   State Health Official directive #16-007, dated April 28, 2016, Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-3-104, C.R.S. (2016)

Initial Review — Final Adoption
Proposed Effective Date **09/09/16** — Emergency Adoption **09/09/16**

DOCUMENT #01

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Title of Rule: Revision to the Special Financing Division Colorado Indigent Care Program Rule Concerning Halfway House Residents, Section 8.904F
Rule Number: MSB 16-07-18-A
Division / Contact / Phone: Special Financing / Taryn Jorgensen / 303-866-5634

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 currently specifically excludes any Colorado resident residing in a halfway house from qualifying for the Colorado Indigent Care Program (CICP) unless they have been released on parole. This rule update will simply allow these individuals to be screened for the CICP and made eligible if they meet all qualifying criteria, and will not change any processes currently in place, nor will it place any new requirements on the Department, CICP providers, CICP clients, or CICP applicants.

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 will allow Colorado residents residing in community corrections facilities (halfway houses) who have freedom of movement and association to be eligible for the CICP if they are found to be ineligible for Medicaid due to being over income or if they are legal immigrants who have not been in the country for at least five years. The Department and the Department of Public Safety have determined that all but one community corrections facility in Colorado (Gateway Through the Rockies in Colorado Springs) allow residents freedom of movement and association and meet the definition provided by CMS.

   It is not possible to quantify the impact of this proposed change because although the Department of Health Care Policy and Financing has determined that about 4,000 people will be affected by this change for Medicaid, the Department does not know how many of those 4,000 or on top of those 4,000 will qualify for the CICP. However, the Department does assume the number to be fewer than 4,000.

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

   The Department of Health Care Policy and Financing sees no fiscal impact of this rule change for the Department. The funds for the Colorado Indigent Care Program are appropriated, and this rule update will have no effect on the appropriation.

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

   The update to this rule will help to ensure that people who are transitioning from the prison system back into the general public will be eligible for more affordable health care through the CICP should they not qualify for Medicaid. Otherwise, this population may go without access to affordable health care until they can purchase a plan through Connect for Health Colorado during open enrollment or qualify for coverage through their employer.

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

   Since the Department of Health Care Policy and Financing does not foresee any fiscal impact of this rule change, there are not any less costly methods that were considered.

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

   No other methods were considered.

8.904 PROVISIONS APPLICABLE TO CLIENTS

F. Applicants Not Eligible

1. The following individuals are not eligible to receive discounted services under available CICP funds:

   a. Individuals for whom lawful presence cannot be verified.

   b. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who ~~have not been released on parole~~ do not have freedom of movement and association, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.

   c. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.

   d. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.

2. Persons who qualify for Medicaid. However, applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICP eligibility:

   a. QMB benefits described at section 10 C.C.R. 2505-10, Section 8.111.1 (2007) of these regulations;

   b. SLMB benefits described at section 10 C.C.R. 2505-10, Section 8.122 (2007), or

   c. The QI1 benefits described at section 10 C.C.R. 2505-10, Section 8.123 (2007).

3. Individuals who are eligible for the Children's Basic Health Plan. However, individuals who are waiting to become an enrollee in the Children's Basic Health Plan and/or have incurred charges at a participating qualified health care provider in the 90 days prior to the application date shall not be excluded from consideration for eligibility on a temporary basis. Once the applicant becomes enrolled in the Children's Basic Health Plan, the applicant is no longer eligible to receive discounted health care services under available CICP funding.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Special Financing Division Colorado Indigent Care Program Rule Concerning Establishing Lawful Presence, Section 8.904C
Rule Number: MSB 16-01-20-A
Division / Contact / Phone: Special Financing / Taryn Jorgensen / 303-866-5634

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 16-01-20-A, Revision to the Special Financing Division Colorado Indigent Care Program Rule Concerning Establishing Lawful Presence, Section 8.904C
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) 8.904, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	9/9/2016
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace current text beginning at 8.904C.1 through the end of 8.904C.6 with the new text provided. This revision is effective 11/30/2016.

DO NOT PUBLISH THIS PAGE

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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).

   Department of Revenue is in the process of updating their rules for evidence of lawful presence. The Colorado Indigent Care Program must update its rules as well to coincide with the changes to Department of Revenue's rule.

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:

   Emergency rule-making is imperatively necessary in order for the Colorado Indigent Care Program to implement the Department of Revenue update of the evidence of lawful presence requirements, as required under state law. There are also a number of people who are turned away from services under the Colorado Indigent Care Program because the lawful presence documentation they have is not accepted under the current rule. This rule update broadens the scope of acceptable documentation for establishing lawful presence and will allow applicants who are lawfully present to qualify for the program, assuming they meet all other eligibility criteria.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   24-76.5-101 et. al., C.R.S. (2015)
   25.5-3-101 through 25.5-3-111, C.R.S. (2015)

Title of Rule: Revision to the Special Financing Division Colorado Indigent Care Program Rule Concerning Establishing Lawful Presence, Section 8.904C
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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 currently requires Colorado Indigent Care Program (CICP) applicants 18 years of age or older to execute an affidavit concerning lawful presence status and present documentation that verifies their lawful presence in the United States in order to receive discounted health care services. This rule update will not change this process, nor will it place any new requirements on the Department, CICP providers, CICP clients, or CICP applicants.

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 will make it easier for some individuals to qualify for the Colorado Indigent Care Program due to the expansion of the documents allowable to verify lawful presence. It is not possible to quantify the impact of this because the Department of Health Care Policy and Financing does not currently know who these individuals are. Colorado Indigent Care Program providers determine eligibility for the program in accordance with state rules and guidance.

   This rule should not impact providers who participate in the Colorado Indigent Care Program, as the processes of verifying lawful presence documents is already in place.

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

   The Department of Health Care Policy and Financing sees no fiscal impact of this rule change for the Department. The funds for the Colorado Indigent Care Program are appropriated, and this rule update will have no effect on the appropriation.

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

The Department is required to comply with C.R.S. § 24-76.5-103, which it does through the implementation of, and necessary amendments to, this rule.

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

   The Department is required to comply with C.R.S. § 24-76.5-103, which it does through the implementation of, and necessary amendments to, this rule.

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

   No other methods were considered.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

In order to qualify to receive discounted health care services under available CICP funds, an applicant shall satisfy the following requirements:

1. Execute an affidavit regarding citizenship status;

2. Be lawfully present in the United States;

3. Be a resident of Colorado;

4. Meet all CICP eligibility requirements as defined by state law and procedures; and

5. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, where required by 10 C.C.R. 2505-10, Section 8.904.E (2007.)

B. Affidavit

1. Each first-time applicant, or applicant seeking to reapply, eighteen (18) years of age or older shall execute an affidavit stating:

   a. That he or she is a United States citizen, or

   b. That he or she is a legal permanent resident, or is otherwise lawfully present in the United States pursuant to federal law.

2. For an applicant who has executed an affidavit stating that he or she is lawfully present in the United States but is not a United States citizen, the provider shall, within 30 days of the application date, verify lawful presence through the Federal Systematic Alien Verification of Entitlement Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security. Until verification of lawful presence is made, the affidavit may be presumed to be proof of lawful presence.

C. Establishing Lawful Presence

1. Each first-time applicant, or applicant seeking to reapply, eighteen (18) years of age or older shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective August 30, 2016), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request. ~~one of the following. Any document submitted pursuant to 8.904.C.1 shall be presumed to be genuine unless there is a reasonable basis for questioning the authenticity of the document.~~

~~a. A valid Colorado Driver's License or a Colorado Identification Card, issued pursuant to Article 2 of Title 42, C.R.S. A valid Colorado Driver's License or Identification Card includes only a current Driver's License, Minor Driver's License, Probationary Driver's~~

License, Commercial Driver's License, Restricted Driver's License, Instruction Permit or Identification Card.

b. A United States Military Identification Card or a Military Dependents' Identification Card;

c. A United States Coast Guard Merchant Mariner Card;

d. A Native American Tribal Document; OR

e. A driver's license or state-issued identification card issued in a state approved by the Director, Motor Vehicle Division, Department of Revenue.

2. If an applicant is unable to provide a document listed in 8.904.C.1, then he/she must provide a document listed in 8.904.C.2. Any document submitted pursuant to 8.904.C.2 shall be presumed to be genuine unless there is a reasonable basis for questioning the authenticity of the document.

a. Documents applicable to U.S. citizens and non-citizen nationals

I. Copy of applicant's birth certificate from any state, the District of Columbia and all United States territories.

II. United States Passports, except for "limited" passports issued for less than five years.

III. Report of Birth Abroad of a United States Citizen, form FS-20.

IV. Certificate of Birth issued by a foreign service post (FS-545) or Certification of Report of Birth (DS-1350).

V. Certification of Naturalization (N-550 or N-570).

VI. Certificate of Citizenship (N-560 or N-561).

VII. U. S. Citizen Identification Card (I-97).

VIII. Northern Mariana Identification Card for an applicant born prior to November 3, 1986.

IX. Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen.

X. American Indian Card with classification code "KIC" and a statement on the back identifying U.S. Citizen members of the Texas Band of Kickapoos.

XI. Religious records recorded in one of the fifty states, the District of Columbia or U.S. territories issued within three months after birth showing that the birth occurred in such jurisdiction and the date of the birth or the individual's age at the time the record was made.

XII. Evidence of civil service employment by the U.S. government before June 1, 1976.

XIII. Early school records showing the date of admission to the school, the child's date and place of birth and the names' and places of birth of the parents;

XIV. Census record showing name, U.S. citizenship or a U.S. place of birth or age of applicant;

XV. Adoption Finalization Papers showing the child's name and place of birth in one of the 50 states, D.C., or U.S. territories or where the adoption is not finalized and the State or other jurisdiction listed above in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency showing the child's name and place of birth in one of such jurisdictions. The source of the information must be an original birth certificate and must be indicated in the statement; or

XVI. Any other document that establishes a U.S. place of birth or in some way indicates U.S. citizenship.

XVII. A written declaration, which shall be either:

a) A written declaration from one or more third parties made under penalty of perjury and possibly subject to later verification of status, indicating a reasonable basis for personal knowledge that the applicant is a U.S. citizen or non-citizen national, or

b) The applicant's written declaration, made under penalty of perjury and possibly subject to later verification of status that he or she is a U.S. citizen or non-citizen national.

XVIII. The following documents may be accepted as evidence of U.S. citizenship for collectively naturalized individuals:

a) Puerto Rico

1) Evidence of birth in PR on or after April 11, 1899 and the applicants' statement that he or she was residing in the U.S., a U.S. possession, or PR on January 13, 1941; or

2) Evidence that the applicant was a PR citizen and the applicant's statement that he or she was residing in PR on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

b) U.S. Virgin Islands

1) Evidence of birth in the U.S. Virgin Islands (VI) and the applicant's statement of residence in the U.S., a U.S. possession, or the U.S. VI on February 25, 1927; or

2) The applicant's statement indicating residence in the U.S. VI as a Danish citizen on January 17, 1917 and that he or she did not make a declaration to maintain Danish citizenship; or

3) Evidence of birth in the U.S. VI and the applicant's statement indicating residence in the U.S., U.S. Possession or Territory or the Canal Zone on June 28, 1932.

c) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)

1) Evidence of birth in NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

2) Evidence of TTPI citizenship in the NMI since before November 3, 1981(NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

XIX. Derivative U.S. Citizenship may be determined as follows:

a) Applicant born abroad to two U.S. citizens:

1) The applicant shall present evidence of U.S. citizenship of the parents and the relationship of the applicant to the parents, and the evidence that at least one parent resided in the U.S. or an outlying possession prior to the applicant's birth.

b) Applicant born abroad to a U.S. citizen parent and a U.S. non-citizen national parent:

1) The applicant shall present evidence that one parent is a U.S. citizen and the other is a U.S. non-citizen national, evidence of the relationship of the applicant to the U.S. citizen parent and the evidence the U.S. citizen parent resided in the U.S., a U.S. possession, American Samoa or Swain's Island for a period of at least one year prior to the applicant's birth.

c) Applicant born out of wedlock abroad to a U.S. citizen mother:

1) The applicant shall present evidence of U.S. citizenship of the mother, evidence of the relationship to the applicant and, for births on or before December 24, 1952, evidence that the mother resided in the U.S. prior to the applicant's birth or, for births after December 24, 1952, evidence that the mother had resided, prior to the child's birth, in the U.S. or a U.S. possession for a period of one year.

d) Applicant born in the Canal Zone or the Republic of Panama:

1) The applicant shall present a birth certificate showing birth in the Canal Zone on or after February 26, 1904 and before October 1, 1979 and evidence that one parent was a U.S. citizen at the time of the applicant's birth; or

2) A birth certificate showing birth in the Republic of Panama on or after February 26, 1904 and before October 1, 1979 and evidence that at least one parent was a U.S. citizen and employed by the U.S. government or the Panama Railroad Company or its successor in title.

e) All other situations where an applicant claims to have a U.S. citizen parent and an alien parent, or claims to fall within one of the above categories but is unable to present the listed documentation:

1) If the applicant is in the U.S., refer him or her to the local Department of Homeland Security (formerly known as the Immigration and Naturalization Service, or INS) office for determination of U.S. citizenship; or

2) If the applicant is outside the U.S., refer him or her to the State Department consular office for a U.S. citizenship determination.

XX. Adoption of foreign-born child by U.S. citizen:

a) If the birth certificate shows a foreign place of birth and the applicant cannot be determined to be a naturalized citizen under any of the above criteria, refer the applicant

~~to the local Department of Homeland Security office for a determination of U.S. citizenship.~~

~~XXI. U.S. citizenship by marriage:~~

~~a) The applicant shall present evidence that she was married to a U.S. citizen before September 22, 1922, or~~

~~b) If the husband was an alien at the time of their marriage, that the husband became a U.S. citizen before September 22, 1922.~~

~~c) If the marriage was later terminated, the woman shall demonstrate that she resided in the U.S. at the time it was terminated and that she has continued to reside in the U.S.~~

~~b. Documents applicable to non-U.S. citizens~~

~~I. Alien lawfully admitted for permanent residence~~

~~a) Department of Homeland Security Form I-551, Alien Registration Receipt Card, commonly called or known as a "green card"; or~~

~~b) Unexpired Temporary I-551 Stamp in foreign passport or on Department of Homeland Security Form I-94.~~

~~II. Asylee~~

~~a) Department of Homeland Security Form I-94 annotated with stamp showing grant of asylum under section 208 of the Immigration and Nationality Act (INA); or~~

~~b) Department of Homeland Security Form I-688B (Employment Authorization Card) annotated "274a.12(a)(5)"; or~~

~~c) Department of Homeland Security Form I-776 (Employment Authorization Document) annotated "A5"; or~~

~~d) Grant Letter from the Asylum Office or U.S.C.I.S..~~

~~III. Refugee~~

~~a) Department of Homeland Security Form I-94 annotated with stamp showing admission under Section 207 of the INA; or~~

~~b) Department of Homeland Security Form I-688B (Employment Authorization Card) annotated "274a.12(a)(3)"; or~~

~~c) Department of Homeland Security Form I-766 (Employment Authorization Document) annotated "A3"; or~~

~~d) Department of Homeland Security Form I-571(Refugee Travel Document); or~~

~~e) I-765 Employment Authorization Document; or~~

~~f) Grant letter from the U.S. Department of Health and Human Services granting refugee status to human trafficking victims.~~

~~IV. Alien paroled into the U.S. for a least one year~~

~~a) Department of Homeland Security Form I-94 with stamp showing admission for at least one year under Section 212(d)(5) of the INA. (Applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement).~~

~~V. Alien whose deportation or removal was withheld~~

~~a) Department of Homeland Security Form I-688B (Employment Authorization Card) annotated "274a.12(a)(10)"; or~~

~~b) Department of Homeland Security Form I-766 Employment Authorization Document annotated "A10"; or~~

~~c) Order from an immigration Judge showing deportation withheld under Section 243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under Section 241(b)(3) of the INA.~~

~~VI. Alien granted conditional entry~~

~~a) Department of Homeland Security Form I-94 with stamp showing admission under Section 203(a)(7)of the INA; or~~

~~b) Department of Homeland Security Form I-688B (Employment Authorization Card) annotated "A3"; or~~

~~c) Department of Homeland Security Form I-766 (Employment Authorization Document) annotated "A3".~~

~~VII. Cuban / Haitian entrant~~

~~a) Department of Homeland Security Form I-551, Alien Registration Receipt Card, commonly known as the "Green Card" with the code CU6, CU7, or CH6; or~~

~~b) Unexpired temporary I-551 stamp in foreign passport or on Department of Homeland Security Form I-94 with the code CU6, CU7, or CH6; or~~

~~c) Department of Homeland Security Form I-94 with stamp showing parole as "Cuba/Haitian Entrant" under Section 212(d) (5) of the INA.~~

~~VIII. Alien who has been battered or subjected to extreme cruelty~~

~~a) See Attachment 5, Exhibit B, at U.S. Attorney General Order No. 2129-97. The documentation for Violence Against Women Act self- petitioners is the Department of Homeland Security issued "Notice of Prima Facie Determination" or "Notice of Approval".~~

~~3. If an individual is unable to present any of the documents listed in 8.904.C.1 and 8.904.C.2 the provider may accept a waiver. A first-time applicant or applicant seeking to reapply may demonstrate lawful presence by executing both the affidavit required in 8.904.B. and by executing a Request for Waiver. The Request for Waiver form, seeking a determination of lawful presence by the Department of Revenue, may be completed by the applicant or the applicant's representative. The Request for Waiver must be accompanied by all documents that the applicant is able to produce to assist in verification of lawful presence.~~

~~4~~2. Submission, Receipt and Retention of Documentation

a. Lawful presence documentation may be accepted from the applicant, the applicant's spouse, parent, guardian, or authorized representative in person, by mail, or facsimile.

b. Providers shall develop procedures for handling original documents to ensure that the documents are not lost, damaged or destroyed. Providers shall develop and follow procedures for returning or mailing original documents to applicants within five business days of receipt.

c. Providers shall accept copies of an applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter, provided that the verification identifies that the copy is from an original and that the individual who reviewed the document(s) signifies such by including their name, organization, address, telephone number and signature on the copy.

d. The qualified health care provider shall retain photocopies of the affidavit and lawful presence documentation ~~listed in 8.904.C~~ with the application.

~~5~~3. Expired or absent documentation for non-U.S. citizens

a. If an applicant presents expired documents or is unable to present any documentation evidencing his or her immigration status, refer the applicant to the local Department of Homeland Security office to obtain documentation of status.

b. In unusual circumstances involving applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the applicant can provide an alien registration number, the provider may file U.S.C.I.S. Form G-845 and Supplement, along with the alien registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status.

c. If an applicant presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document ~~for one of the documents listed in 8.904.2.b~~, file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify status.

~~6~~4. The provider shall not discriminate against applicants on the basis of race, national origin, gender, religion, age or disability. If an applicant has a disability that limits the applicant's ability to provide the required evidence of citizenship or lawful presence, the provider shall assist the individual to obtain the required evidence.

a. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the applicant may provide the required documentation; or referring the client to other agencies or organizations which may be able to provide assistance.

b. Examples of additional assistance that shall be provided to applicants who are unable to comply with the documentation requirements due to physical or mental

impairments or homelessness and who do not have a guardian or representative who can provide assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the applicant.

c. The provider shall not be required to pay for the cost of obtaining required documentation.

d. The provider shall document its efforts of providing additional assistance to the client. Documentation of such shall be retained in the applicant's application file.