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Title of Rule: Revision to the Medical Assistance Rule concerning Eliminating the Adult Dental Cap, Section 8.201.6.

Rule Number: MSB 24-03-04-A

Division / Contact / Phone: Health Programs Office / Alex Lyons / alex.lyons@state.co.us

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 24-03-04-A, Revision to the Medical Assistance Rule concerning Eliminating the Adult Dental Cap, Section 8.201.6.
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) 8.201.6
5. Does this action involve any temporary or emergency rule(s)? No
If yes, state effective date:
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.201.6 with the proposed language beginning at 8.201.6.1 through the end of 8.201.6.2. This rule is effective September 30, 2024.

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Rule Number: MSB 24-03-04-A

Division / Contact / Phone: Health Programs Office / Alex Lyons / alex.lyons@state.co.us

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 proposed rule is designed to align the Department's regulatory language with the 2023 Long Bill and corresponding changes to the Medicaid State Plan.

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:

2. Federal authority for the Rule, if any:

3. State Authority for the Rule:

CO SB 23-214 (2023 Long Bill)

25.5-1-301-303 C.R.S. (2024)

Initial Review

07/12/24 Final Adoption

08/09/24

Proposed Effective Date

09/30/24 Emergency Adoption

DOCUMENT #10

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Title of Rule: Revision to the Medical Assistance Rule concerning Eliminating the Adult Dental Cap, Section 8.201.6.

Rule Number: MSB 24-03-04-A

Division / Contact / Phone: Health Programs Office / Alex Lyons / alex.lyons@state.co.us

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.

Adult Medicaid members will benefit from the proposed rule because they will no longer face annual financial limits on the dental services they may receive. The costs of this rule will be borne, as with Medicaid expenses generally, by a combination of state and federal funds.

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 main class of persons affected by this rule will be Medicaid members, who will benefit from greater access to adult dental services.

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

There are unlikely to be significant costs associated with implementing and enforcing the proposed rule because it merely enacts changes already mandated by state law.

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

The benefit of implementing the proposed rule is that the Department will be compliant with state law and Medicaid members will have expanded access to adult dental services. The cost of inaction will be that the Department is out of compliance with state law.

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

There is likely no less costly method to achieve the proposed rule's purpose, because the changes the rule enacts are directly mandated by state legislation.

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

The Department did not consider any alternatives to the proposed rule because the changes it implements were mandated by the 2023 Long Bill.

8.201 ADULT DENTAL SERVICES

8.201.6 ANNUAL LIMITS

1. ~~Beginning July 1, 2019, dental services for Adult Clients age 21 years and older shall be limited to a total of \$1,500 per Medicaid Adult Client per state fiscal year. An Adult Client may make personal expenditures for any dental services that exceed the \$1,500 annual limit. Dental services for Adult Clients performed~~provided on or after August 1, 2024, shall not be subject to an annual or lifetime financial limit. ~~n annual or lifetime financial limit~~
2. ~~The complete and partial dentures benefit shall be subject to~~require prior authorization to be eligible for reimbursement and will be reimbursed in the amount set forth in the Medicaid Dental Fee-for-Service Fee Schedule in effect on the date of service. and shall not be subject to the annual maximum for dental services for Adult Clients age 21 years and older. Although the complete and partial dentures benefit is not subject to the annual maximum for the adult dental services, it shall be subject to a set Medicaid allowable rate.

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Title of Rule: Revision to the Medical Assistance Rule concerning COVID-19 Vaccine and Monoclonal Antibody and Antiviral Treatment, Section 8.700.6.B.9-11

Rule Number: MSB 24-04-10-A

Division / Contact / Phone: Rates Division / Susan Green / 303-866-6181

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 24-04-10-A Revision to the Medical Assistance Rule concerning COVID-19 Vaccine and Monoclonal Antibody and Antiviral Treatment, Section 8.700.6.B.9-11

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) 8.700.6.B.9-11, 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)?

If yes, state effective date:

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700.6.B with the proposed text beginning at 8.700.6.B.9 through the end of 8.700.6.B.11. This rule is effective September 30, 2024.

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Title of Rule: Revision to the Medical Assistance Rule concerning COVID-19 Vaccine and Monoclonal Antibody and Antiviral Treatment, Section 8.700.6.B.9-11

Rule Number: MSB 24-04-10-A

Division / Contact / Phone: Rates Division / Susan Green / 303-866-6181

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 is to change Federally Qualified Health Center (FQHC) reimbursement for the COVID-19 vaccine and monoclonal antibody and antiviral treatment when administered in an outpatient setting. During the public health emergency (PHE), in accordance with the American Rescue Plan Act, State Medicaid programs provide coverage without cost sharing for COVID-19 vaccines, monoclonal antibody and antiviral treatment. The COVID-19 public health emergency (PHE) ended on May 11, 2023 and mandatory coverage will end on September 30, 2024. This rule removes the FQHC reimbursement of these services at the lower of the submitted charges and the Department fee schedule and the carveout of these services from FQHC encounter rates. Going forward, the reimbursement of these services will be included in the FQHC encounter rate instead of being separately reimbursed. Members will continue to have access to these services.

2. An emergency rule-making is imperatively necessary

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

Explain:

3. Federal authority for the Rule, if any:

Section 1902(bb) of the Social Security Act (42 U.S.C.A. § 1396a(bb))

4. State Authority for the Rule:

Initial Review **07/12/24**

Final Adoption **08/09/24**

Proposed Effective Date **09/30/24**

Emergency Adoption

DOCUMENT #11

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Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024); Section 25.5-5-102(1)(m), C.R.S. (2024); State Plan Attachment 3.1-A 2.c. and Attachment 4.19-B

Initial Review **07/12/24**

Final Adoption **08/09/24**

Proposed Effective Date **09/30/24**

Emergency Adoption

DOCUMENT #11

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning COVID-19 Vaccine and Monoclonal Antibody and Antiviral Treatment, Section 8.700.6.B.9-11

Rule Number: MSB 24-04-10-A

Division / Contact / Phone: Rates Division / Susan Green / 303-866-6181

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.

Federally Qualified Health Centers will be impacted by this rule. This rule revision will change the way that FQHCs are reimbursed for providing COVID-19 vaccines and monoclonal antibody and antiviral treatments in an outpatient setting. FQHCs will not incur budgetary concerns to provide these services as their costs will be included in the encounter rate with the elimination of the carveout of these services. Medicaid members will continue to have access to these services at FQHCs.

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 reimburse FQHCs for the cost of these services indirectly through their encounter rates in the future instead of directly. While members will continue to have access to these services, the need for these services is declining.

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

This rule revision will minimally impact the Department and state revenues. The Department will indirectly reimburse FQHCs for administering the COVID-19 vaccines and monoclonal antibody and antiviral treatment in the outpatient setting. Without this revision to the rule, the costs of these services would continue to be directly reimbursed at the lower of submitted charges and the Department fee schedule.

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

If the Department does not adopt this rule change the Department and FQHCs will have the administrative burden of continuing to separately bill and carve out the costs of these services from the encounter rate for these services that are declining in frequency. The payment of the costs of these services within the encounter rate eliminates this administrative burden.

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

There are no other methods that are less costly or less intrusive 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.

No alternative methods for achieving the purpose of the proposed rule were seriously considered by the Department.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.6 REIMBURSEMENT

8.700.6.A FQHCs shall be reimbursed separate per visit encounter rates based on 100% of reasonable cost for physical health services, dental services, and specialty behavioral health services. An FQHC may be reimbursed for up to three separate encounters with the same client occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: physical health encounter, dental encounter, or specialty behavioral health encounter. Distinct dental encounters are allowable only when rendered services are covered and paid by the Department's dental Administrative Service Organization (ASO). Distinct specialty behavioral health encounters are allowable only when rendered services are covered and paid by either the Regional Accountable Entity (RAE) or through the short-term behavioral health services in the primary care setting policy.

8.700.6.B The following services are reimbursed separately from the FQHC encounter rate. These services shall be reimbursed in accordance with the following:

1. Long-Acting Reversible Contraception (LARC) devices shall be reimbursed separately from the FQHC encounter rate. In addition to payment of the encounter rate for the insertion of the device(s), the LARC device(s) must be billed in accordance with Section 8.730 and shall be reimbursed the lower of:
 - a. Submitted charges; or
 - b. Fee schedule as determined by the Department.
2. Services provided in an inpatient hospital setting shall be reimbursed the lower of:
 - a. Submitted charges; or
 - b. Fee schedule as determined by the Department.
3. The provision of complete dentures and partial dentures must be billed in accordance with Section 8.201. and Section 8.202. and shall be reimbursed the lower of:
 - a. Submitted charges; or
 - b. Fee schedule as determined by the Department.
4. Dental services provided in an outpatient hospital setting shall be reimbursed the lower of:
 - a. Submitted charges; or
 - b. Fee schedule as determined by the Department.
5. The Prenatal Plus Program shall be billed and reimbursed in accordance with Section 8.748.

6. The Nurse Home Visitor Program shall be billed and reimbursed in accordance with Section 8.749.
7. An FQHC that operates its own pharmacy that serves Medicaid clients must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number in accordance with Section 8.800.
8. Antagonist injections for substance use disorders provided at the FQHC shall be reimbursed the lower of:
 - a. Submitted charges; or
 - b. Fee schedule as determined by the Department.
- ~~9. COVID-19 vaccine administration provided at the FQHC shall be reimbursed the lower of:
 - a. Submitted charges; or
 - b. Fee schedule as determined by the Department~~
- ~~10. Monoclonal Antibody COVID-19 infusion administration provided at the FQHC shall be reimbursed the lower of:
 - a. Submitted charges; or
 - b. Fee schedule as determined by the Department.~~
- ~~11. COVID-19 antiviral medication, remdesivir, provided at the FQHC shall be reimbursed the lower of:
 - a. Submitted charges; or
 - b. Fee schedule as determined by the Department.~~

8.700.6.C A physical health encounter, a dental encounter, and a specialty behavioral health encounter on the same day and at the same location shall count as three separate visits.

1. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

8.700.6.D Encounter rates calculations

Effective July 1, 2018, FQHCs will be paid three separate encounter rates for three separate services: physical health services, dental services, and specialty behavioral health services. Physical health services are covered services reimbursed through the Department's MMIS, except the short-term behavioral health services in the primary care setting policy. Dental services are services provided by a dentist or dental hygienist that are reimbursed by the Department's dental ASO. Specialty behavioral health services are behavioral health services covered and reimbursed by either the RAE or by the MMIS through the short-term behavioral health services in the primary care setting policy. The Department will perform an annual reconciliation to ensure each FQHC has been paid at least their per visit Prospective Payment System (PPS) rate. If an FQHC has been paid

below their per visit PPS rate, the Department shall make a one-time payment to make up for the difference.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, Dec. 21, 2000. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

Copies are available for a reasonable charge and for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. Each alternative payment rate shall be the lower of the service specific annual rate or the service specific base rate. The annual rate and the base rate shall be calculated as follows:
 - a. The annual rate for the physical health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for physical health services and visits. The annual rate for the dental rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for dental services and visits provided by a dentist or dental hygienist. The annual rate for the specialty behavioral health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for behavioral health services and visits either covered and reimbursed by the RAE or by the short-term behavioral health services in the primary care setting policy.
 - b. The new base rates shall be the audited, calculated, inflated, and weighted average encounter rate for each separate rate, for the past three years. Base rates are recalculated (rebased) annually. Initial Base rates shall be calculated when the Department has two year's data of costs and visits.
 - c. Beginning July 1, 2020, a portion of the FQHCs physical health alternative payment methodology rates are at-risk based on the FQHC's quality modifier. An FQHC's quality modifier is determined by the FQHC's performance on quality indicators in the previous Calendar Year.
3. New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set reimbursement base rates for the first year. The base rates shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as an FQHC. These shall be the FQHCs base rates until the FQHC's final base rates are set.
 - a. New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.
4. The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate

supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate.

- a. Freestanding and hospital-based FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. An extension of up to 75 days may be granted based upon circumstances. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.
 - b. The new reimbursement encounter rates for FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement encounter rates (if less than the new audited rate) shall remain in effect for an additional day above the 120-day limit for each day the required information is late; if the old reimbursement encounter rates are more than the new rate, the new rates shall be effective the 120th day after the FQHCs fiscal year end.
 - c. Effective December 11, 2020, FQHC cost reports with fiscal year ends between May 31, 2020 and March 31, 2021 will be set using the previous year's rates multiplied by the Medicare Economic Index (MEI).
 - d. Effective September 28, 2021, FQHC cost reports with fiscal year ends between May 31, 2021 and March 31, 2022 will be set using the previous year's rates multiplied by 2.7%.
 - e. Starting with FQHC cost reports with fiscal year end May 31, 2022 the Department will restart the base rate setting process. For the first cost report submitted by an FQHC with fiscal year end May 31, 2022 and after, base rates will be set based on one year's worth of data. For the second cost report submitted by an FQHC with fiscal year end May 31, 2022 and after, base rates will be set as a weighted average of two years' worth of data. After this, base rates will be set as specified in 8.700.6.D.2.
5. If an FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.
- a. An FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC. The documented change in the scope of service of the FQHC must meet all of the following conditions:
 - i. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.
 - ii. The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5.

- iii. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.
 - iv. The net change in the FQHC's per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change.
 - v. The change in scope of service must have existed for at least a full six (6) months.
- b. A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must meet the conditions set forth in Section 8.700.6.D.5.b and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.
- i. The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;
 - ii. The addition or deletion of a covered Medicaid service under the State Plan;
 - iii. Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;
 - iv. Changes in service due to a change in applicable technology and/or medical practices utilized by the FQHC;
 - v. Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;
 - vi. Changes resulting from a change in the provider mix, including, but not limited to:
 - a. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the FQHC;
 - b. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the FQHC (e.g. delivery services);
 - c. Indirect medical education adjustments and a direct graduate medical education payment that reflects the

costs of providing teaching services to interns and/or residents; or,

- d. Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

- c. The following items do not prompt a scope-of-service rate adjustment:

- i. An increase or decrease in the cost of supplies or existing services;
- ii. An increase or decrease in the number of encounters;
- iii. Changes in office hours or location not directly related to a change in scope of service;
- iv. Changes in equipment or supplies not directly related to a change in scope of service;
- v. Expansion or remodel not directly related to a change in scope of service;
- vi. The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services;
- vii. The addition or removal of administrative staff;
- viii. The addition or removal of staff members to or from an existing service;
- ix. Changes in salaries and benefits not directly related to a change in scope of service;
- x. Change in patient type and volume without changes in type, duration, or intensity of services;
- xi. Capital expenditures for losses covered by insurance; or,
- xii. A change in ownership.

- d. An FQHC must apply to the Department by written notice within ninety (90) days of the end of the FQHCs fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC's annual cost report. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

- e. Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.D.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid

change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. An FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

- f. The documentation for the scope-of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope-of-service rate adjustment must submit the following to the Department:
 - i. The Department's application form for a scope-of-service rate adjustment, which includes:
 - a. The provider number(s) that is/are affected by the change(s) in scope of service;
 - b. A date on which the change(s) in scope of service was/were implemented;
 - c. A brief narrative description of each change in scope of service, including how services were provided both before and after the change;
 - d. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and
 - e. An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC;
 - ii. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.
- g. The reimbursement rate for a scope-of-service change applied for January 30, 2017 or afterwards will be calculated as follows:
 - i. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also

calculate the Adjustment Factor (AF = covered health care costs/total cost of FQHC services) associated with the change in scope of service of the FQHC. If the AF is 80% or greater, the Department will accept the total costs as filed by the FQHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the FQHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

- ii. The Department will then use the appropriate costs and visits data to calculate the adjusted PPS rate. The adjusted PPS rate will be the average of the costs/visits rate before and after the change in scope of service, weighted by visits.
 - iii. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. The "current PPS rate" means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.
 - iv. The Department will check that the adjusted PPS rate meets the 3% threshold described above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.
 - v. Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.
- h. The Department will review the submitted documentation and will notify the FQHC in writing within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC's fiscal year end.
- i. Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified by the Department through an audit or review process.
- i. If the Department identifies a change in scope of services, the Department may request the documentation as described in Section 8.700.6.D.5.g from the FQHC. The FQHC must submit the documentation within ninety (90) days from the date of the request.
 - ii. The rate adjustment methodology will be the same as described in Section 8.700.6.D.5.h.
 - iii. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the

application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable.

- iv. The effective date of the scope-of-service rate adjustment will be one hundred twenty (120) days after the end of the fiscal year in which the change in scope of service occurred.
 - j. An FQHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, an FQHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.
- 6. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual". If an FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.
 - 7. Pending federal approval, the Department will offer a second Alternative Payment Methodology (APM 2) that will reimburse FQHCs a Per Member Per Month (PMPM) rate. FQHCs may opt into APM 2 annually. This reimbursement methodology will convert the FQHC's current Physical Health cost per visit rate into an equivalent PMPM rate using historical patient utilization, member designated attribution, and the Physical Health cost per visit rate for the specific FQHC. Physical health services rendered to patients not attributed to the FQHC, or attributed based on geographic location, will pay at the appropriate encounter rate. Dental and specialty behavioral health services for all patients will be paid at the appropriate encounter rate. Year 2 rates for FQHCs participating in APM 2 will be set using trended data. Year 3 rates will be set using actual data.
 - 8. The Department will perform an annual reconciliation to ensure the PMPM reimbursement compensates APM 2 providers in an amount that is no less than their PPS per visit rate. The Department shall perform PPS reconciliations should the FQHC participating in APM 2 realize additional cost, not otherwise reimbursed under the PMPM, incurred as a result of extraordinary circumstances that cause traditional encounters to increase to a level where PMPM reimbursement is not sufficient for the operation of the FQHC.
 - 9. PMPM and encounter rates for FQHC participating in APM 2 shall be effective on the 1st day of the month that falls at least 120 days after an FQHC's fiscal year end.

8.700.6.E The Department shall notify the FQHC of its rates.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Healthcare Affordability and Sustainability Provider Fees and Supplemental Payments, Section 8.3000

Rule Number: MSB 24-06-24-A

Division / Contact / Phone: External Relations / Jeff Wittreich / 2456

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 24-06-24-A, Revision to the Medical Assistance Act Rule concerning Healthcare Affordability and Sustainability Provider Fees and Supplemental Payments, Section 8.3000
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) 8.3000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
If yes, state effective date:
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.3000 with the proposed text beginning at 8.3000.1 through the end of 8.30001.47. Replace the current text at 8.3003 with the proposed text beginning at 8.3003.A through the end of 8.3003.B.3.b. This rule is effective September 30, 2024.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Healthcare Affordability and Sustainability Provider Fees and Supplemental Payments, Section 8.3000
Rule Number: MSB 24-06-24-A
Division / Contact / Phone: External Relations / Jeff Wittreich / 2456

STATEMENT OF BASIS AND PURPOSE

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

The proposed rule revisions include changes to the Healthcare Affordability and Sustainability (HAS) provider fees assessed upon hospitals and the HAS supplemental payments made to hospitals for federal fiscal year (FFY) 2023-24. The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Board approved the calculation of the FFY 2023-24 provider fees and supplemental payments on Monday, June 3, 2024, and recommends the approval of the proposed rule revisions by the MSB.

The provider fees, with federal matching funds, fund the supplemental payments, healthcare coverage to 500,000+ Medicaid & CHP+ expansion members, and related administrative costs. The proposed rule revises the Inpatient per-diem fees (8.3003.B) and Outpatient percentage fees (8.3003.A) such that provider fees with federal matching funds equal the total funding obligation for FFY 2023-24. Also included are revisions to the Disproportionate Share Hospital (DSH) supplemental payment calculation for FFY 2023-24 (8.3004.D), and revisions/additions to the definitions (8.3001).

2. An emergency rule-making is imperatively necessary

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

Explain:

3. Federal authority for the Rule, if any:

42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);

25.5-4-402.4(4)(b), (g), C.R.S.

Initial Review
Proposed Effective Date

[date]
[date]

Final Adoption
Emergency Adoption

[date]
[date]
DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Healthcare Affordability and Sustainability Provider Fees and Supplemental Payments, Section 8.3000

Rule Number: MSB 24-06-24-A

Division / Contact / Phone: External Relations / Jeff Wittreich / 2456

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.

Hospitals will benefit through increased supplemental payments. The state will benefit through increased provider fees collected from hospitals necessary to fund the funding obligation increase for Medicaid & CHP+ expansion populations.

Hospitals will bear the cost through increased provider fees used to fund the funding obligation increase for supplemental payments, Medicaid & CHP+ expansion populations, and administrative costs.

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

The proposed rule revisions will result in a \$12 million net reimbursement (supplemental payments – provider fees) increase to hospitals for FFY 2023-24. The proposed rules will also result in increased provider fees collected necessary to fund the \$14 million funding obligation increase for Medicaid & CHP+ expansion populations and the \$5 million funding obligation increase for administrative costs.

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.

While there are administrative costs, such costs are funded with provider fees with federal Medicaid matching funds. No state General Fund is used.

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

If no action is taken, the Department will not be able to collect sufficient provider fees from hospitals to fully fund supplemental payments, Medicaid & CHP+ expansion populations, and administrative costs to comply with state statute. The state does not currently have the resources to fund the different funding obligation increases in absence of the provider fees.

DO NOT PUBLISH THIS PAGE

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

No other methods are available 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.

No other alternatives are available. The rules are necessary to comply with the Colorado Healthcare Affordability and Sustainability Enterprise Act, under section 25.5-4-402.4, C.R.S.

8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017 (Act), C.R.S. § 25.5-4-402.4, authorizes the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) to assess a healthcare affordability and sustainability fee, pursuant to rules adopted by the State Medical Services Board, to provide business services to hospitals as described in C.R.S. § 25.5-4-402.4(4)(a). These business services include, but are not limited to, obtaining federal financial participation to increase reimbursement to hospitals for care provided under the state medical assistance program (Medicaid) and the Colorado Indigent Care Program (CICP); expanding health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan Plus (CHP+), and for low-income adults without dependent children; providing a Medicaid buy-in program for people with disabilities; implementing twelve month continuous eligibility for Medicaid eligible children; paying CHASE's administrative costs of implementing and administering the Act; consulting with hospitals to help them improve cost efficiency, patient safety, and clinical effectiveness; advising hospitals regarding potential changes to federal and state laws and regulations governing Medicaid; providing coordinating services to hospitals to help them adapt and transition to any new or modified performance tracking and payment systems for the Medicaid program; and providing funding for a health care delivery system reform incentive payments program.

8.3001: DEFINITIONS

- 1.** "Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, § 25.5-4-402.4, C.R.S.
- 2.** "CHASE" or "Enterprise" means the Colorado Healthcare Affordability and Sustainability Enterprise described in C.R.S. § 25.5-4-402.4(3).
- 3.** "CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.
- 4.** "CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.
- 5.** "CMS" means the federal Centers for Medicare and Medicaid Services.
- 6.** "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and [licensed or](#) certified as a critical access hospital by the Colorado Department of Public Health and Environment.
- 7.** "Disproportionate Share Hospital Payment" or "DSH Payment" means the payments made to qualified hospitals that serve a disproportionate share of Medicaid and uninsured individuals as required under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each state that limits federal financial participation for total statewide DSH payments made to hospitals.
- 8.** "Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described in C.R.S. § 25.5-4-402.4(7).
- 9.** "Essential Access Hospital" means a Critical Access Hospital or General Hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget and having 25 or fewer licensed beds.
- 10.** "Exclusive Provider Organization" or "EPO" means a type of managed care health plan where members are not required to select a primary care provider or receive a referral to receive

services from a specialist. EPOs will not cover care provided out-of-network except in an emergency.

11. “Fund” means the healthcare affordability and sustainability fee cash fund described in C.R.S. § 25.5-4-402.4(5).

12. “General Hospital” means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

13. “High Volume Medicaid and CICP Hospital” means a hospital with at least ~~27,500~~ 30,000 Medicaid Days per year that provides over ~~30%~~ 35% of its total days to Medicaid and CICP clients.

14. “Health Maintenance Organization” or “HMO” means a type of managed care health plan that limits coverage to providers who work for or contract with the HMO and requires selection of a primary care provider and referrals to receive services from a specialist. HMOs will not cover care provided out-of-network except in an emergency.

15. “High Medicaid Utilization Hospital” means a hospital with a Medicaid payer mix greater than or equal to twenty-five percent (25%) and a Medicaid non-managed care patient days utilization rate greater than or equal to forty percent (40%).

~~15.~~16. “Heart Institute Hospital” means a hospital recognized as a HeartCARE Center by the American College of Cardiology (ACC) with at least 25,000 Medicaid Non-Managed Care Days per year.

~~16.~~17. “Hospital-Specific Disproportionate Share Hospital Limit” or “Hospital-Specific DSH Limit” means a hospital’s maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.

~~17.~~18. “Hospital Transformation Program Supplemental Medicaid Payments” or “HTP Supplemental Medicaid Payments” means the:

1. Outpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.B.,
2. Inpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.C., and
3. Essential Access Hospital Supplemental Medicaid Payment described in Section 8.3004.E.

~~18.~~19. The HTP Supplemental Medicaid Payments do not include the Hospital Quality Incentive Payment described in Section 8.3004.F. or Rural Support Program Hospital Supplemental Medicaid Payment described in Section 8.3004.G.

~~19.~~20. “Independent Metropolitan Hospital” means an independently owned and operated hospital located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget with at least 1,500 Medicaid Days per year.

~~20.~~21. “Inpatient Services Fee” means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.

~~21.~~22. “Inpatient Upper Payment Limit” means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.

22-23. “Long Term Care Hospital” means a General Hospital that is certified as a long-term care hospital by the Colorado Department of Public Health and Environment.

23-24. “Managed Care Day” means an inpatient hospital day for which the primary payer is a managed care health plan, including HMO, PPO, POS, and EPO days.

24-25. “Medicaid Day” means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.

25-26. “Medicaid Managed Care Day” means a Managed Care Day for which the primary payer is Medicaid.

26-27. “Medicare Cost Report” means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.

27-28. “MMIS” means the Medicaid Management Information System, the Department’s Medicaid claims payment system.

28-29. “MIUR” means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospital days.

29-30. “Neonatal Intensive Care Unit Hospital” or “NICU Hospital” means a hospital with a NICU classification of Level III or IV according to guidelines published by the American Academy of Pediatrics (AAP).

30-31. “Non-Managed Care Day” means an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.

31-32. “Non-State-Owned Government Hospital” means a hospital that is either owned or operated by a local government.

32-33. “Outpatient Services Fee” means an assessment on hospitals based on outpatient hospital charges.

33-34. “Outpatient Upper Payment Limit” means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

34-35. “Pediatric Specialty Hospital” means a hospital that provides care exclusively to pediatric populations.

35-36. “POS” or “Point of Service” means a type of managed care health plan that charges patients less to receive services from providers in the plan’s network and requires a referral from a primary care provider to receive services from a specialist.

36-37. “PPO” or “Preferred Provider Organization” means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost.

37-38. “Privately-Owned Hospital” means a hospital that is privately owned and operated.

38-39. “Psychiatric Hospital” means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

39.40. “Rehabilitation Hospital” means an inpatient rehabilitation facility.

40.41. “Respiratory Hospital” means a hospital that primarily specializes in respiratory related diseases.

41.42. “Rural Hospital” means a hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget.

42.43. “Safety Net Metropolitan Hospital” means a hospital that provides services within the Pueblo, Colorado Metropolitan Statistical Area designated by the United States Office of Management and Budget (Pueblo MSA) with no less than 15,000 Days per year reported on its Medicare Cost Report, Worksheet S-3, Part 1, Column 7 (Title XIX), lines 1-18, and 28 (adult, pediatrics, intensive care, and subunits).

43.44. “State-Owned Government Hospital” means a hospital that is either owned or operated by the State.

44.45. ~~“State University Teaching Hospital”~~ means a High-Volume Medicaid and CICP Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

45.46. “Supplemental Medicaid Payments” means the:

1. Outpatient Hospital Supplemental Medicaid Payment described in 8.3004.B.,
2. Inpatient Hospital Supplemental Medicaid Payment described in 8.3004.C.,
3. Essential Access Hospital Supplemental Medicaid Payment described in 8.3004.E.,
4. Hospital Quality Incentive Payment described in 8.3004.F., and
5. Rural Support Program Hospital Supplemental Medicaid Payment described in 8.3004.G.

46.47. “Uninsured Cost” means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio from the Medicare Cost Report.

~~“Urban Center Safety Net Specialty Hospital” means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICP Days relative to total inpatient hospital days per year, rounded to the nearest percent, equals, or exceeds, 65%~~

8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

8.3003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).
2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.
3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as ~~4.8705%~~1.6625% of total hospital outpatient charges with the following exception.
 - a. High Volume Medicaid and CACP Hospitals' Outpatient Services Fee is discounted to ~~1.8548%~~1.6485% of total hospital outpatient charges.

8.3003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).
2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.
3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of ~~\$114.19~~\$106.01 per day for Managed Care Days and ~~\$510.95~~\$473.90 per day for all Non-Managed Care Days with the following exceptions:
 - a. High Volume Medicaid and CACP Hospitals' Inpatient Services Fee is discounted to ~~\$59.57~~\$55.35 per day for Managed Care Days and ~~\$266.30~~\$247.42 per day for all Non-Managed Care Days, and-
 - b. Essential Access Hospitals' Inpatient Services Fee is discounted to ~~\$45.64~~\$42.40 per day for Managed Care Days and ~~\$204.02~~\$189.56 per day for Non-Managed Care Days.

8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.
 - a. Hospitals that are Colorado Indigent Care Program providers and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.
 - b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.
 - c. Critical Access Hospitals with at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment
2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.
3. Calculation methodology for payment.
 - a. Total funds for the payment shall equal ~~\$244,068,958~~\$257,231,668.
 - b. No qualified hospital shall receive a payment greater than 100% of their Hospital-Specific DSH Limit.
 - c. A qualified hospital with CICP write-off costs greater than 700% of the state-wide average shall receive a payment equal to a minimum of 96.00% of their Hospital-Specific DSH Limit.
 - d. A qualified Critical Access Hospital or Rural Hospital shall receive a payment equal to a minimum of ~~96.00%~~86.00% of their Hospital Specific DSH Limit.
 - e. A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area and having less than ~~2,400~~2,700 Medicaid Days shall receive a payment equal to a minimum of ~~96.00%~~80.00% of their Hospital-Specific DSH Limit.
 - f. All remaining qualified hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining funds.
 - d. No remaining qualified hospital shall receive a payment exceeding 96.00% of their Hospital-Specific DSH Limit as specified in federal regulation. If a qualified hospital's payment exceeds 96.00% of their Hospital-Specific DSH Limit, the payment shall be reduced to 96.00% of the Hospital-Specific DSH Limit. The amount of the reduction shall then be redistributed to other qualified hospitals not exceeding 96.00% of their Hospital Specific DSH Limit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit.
 - e.g. A new CICP hospital shall have their Hospital-Specific DSH Limit equal to 10.00%. A Low MIUR hospital shall have their Hospital-Specific DSH Limit equal 10.00%.
 - i. A new CICP hospital is a hospital approved as a CICP provider after October 1, 2022.

ii. A low MIUR hospital is a hospital with a MIUR less than or equal to 22.50%.

h. The payment percentage of the hospital specific DSH limit shall be published in provider bulletin

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Dental Health Care Program for Low-Income Seniors, Procedure Rate Increase on Schedule A for Fiscal Year 2024-25

Rule Number: MSB 24-06-24-B

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

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 24-06-24-B, Revision to the Medical Assistance Rule concerning Dental Health Care Program for Low-Income Seniors, Procedure Rate Increase on Schedule A for Fiscal Year 2024-25.
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected): Section 8.960
5. Does this action involve any temporary or emergency rule(s)? No
If yes, state effective date:
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.960 Appendix A with the proposed text beginning at Appendix A through the end of Appendix A. This rule is effective September 30, 2024.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Dental Health Care Program for Low-Income Seniors, Procedure Rate Increase on Schedule A for Fiscal Year 2024-25

Rule Number: MSB 24-06-24-B

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

STATEMENT OF BASIS AND PURPOSE

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

Current rule states that the maximum amount per program procedure must not be less than the reimbursement schedule for fee-for-service on Medicaid dental rates. Due to the Medicaid dental rates receiving an increase effective July 1, 2024, many procedures will fall below the base Medicaid dental rates. This change is necessary to stay in compliance with statute.

2. An emergency rule-making is imperatively necessary

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

Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024); Section 25.5-3-404(4), C.R.S.

Initial Review
Proposed Effective Date

09/30/24

Final Adoption
Emergency Adoption

08/09/24

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Dental Health Care Program for Low-Income Seniors, Procedure Rate Increase on Schedule A for Fiscal Year 2024-25

Rule Number: MSB 24-06-24-B

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

REGULATORY ANALYSIS

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

The increase in program rates will not affect any classes and there will be no incurred costs for any classes.

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

There will be no quantitative or qualitative impact to any classes.

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

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

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

There will be no costs to the Department. The benefits will be for the Department to be in compliance with statute.

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

The Department does not foresee any fiscal impact on this rule change and there are not any less costly methods that were considered.

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

DO NOT PUBLISH THIS PAGE

There are no alternative methods for staying in compliance with statute.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.A Definitions

1. Arrange For or Arranging For means demonstrating established relations with Qualified Providers for any of the Covered Dental Care Services not directly provided by the applicant.
2. Covered Dental Care Services include Diagnostic Imaging, Emergency Services, Endodontic Services, Evaluation, Oral and Maxillofacial Surgery, Palliative Treatment, Periodontal Treatment, Preventive Services, Prophylaxis, Removable Prosthesis, and Restorative Services as listed by alphanumeric procedure code in Appendix A.
3. C.R.S. means the Colorado Revised Statutes.
4. Dental Health Professional Shortage Area or Dental HPSA means a geographic area, population group, or facility so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
5. Dental Prosthesis means any device or appliance replacing one or more missing teeth and associated structures if required.
6. Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2020).
7. Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation.
8. Economically Disadvantaged means a person whose Income is at or below 250% of the most recently published federal poverty level for a household of that size.
9. Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior or client is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans.
10. Emergency Services means the need for immediate intervention by a Qualified Provider to stabilize an oral cavity condition.
11. Endodontic Services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues, including pulpectomy.
12. Evaluation means an assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions.
13. Federally Qualified Health Center means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations as defined in 42 U.S.C. section 1395x (aa)(4).
14. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, or interest that are received by an individual or family. Income may be self-declared. Resources are not included in Income.

15. Max Allowable Fee means the total reimbursement listed by procedure for Covered Dental Care Services under the Colorado Dental Health Care Program for Low-Income Seniors in Appendix A. The Max Allowable Fee is the sum of the Program Payment and the Max Client Co-Pay.
16. Max Client Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure in Appendix A for Covered Dental Services under the Colorado Dental Health Care Program for Low-Income Seniors.
17. Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2020).
18. Medicare means the federal health insurance program for people who are 65 or older; certain younger people with disabilities; or people with End-Stage Renal Disease.
19. Medicare Advantage Plans mean the plans offered by Medicare-approved private companies that must follow rules set by Medicare and may provide benefits for services Medicare does not, such as vision, hearing, and dental care.
20. Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (2020).
21. Oral and Maxillofacial Surgery means the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.
22. Palliative Treatment for dental pain means emergency treatment to relieve the client of pain; it is not a mechanism for addressing chronic pain.
23. Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal disease progression.
24. Preventive Services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.
25. Program Payment means the maximum amount by procedure listed in Appendix A for Covered Dental Care Services for which a Qualified Grantee may invoice the Department under the Colorado Dental Health Care Program for Low-Income Seniors. Program Payment must not be less than the reimbursement schedule for fee-for-service dental fees under the medical assistance program established in Articles 4, 5, and 6 of 10 CCR 2505-10.
26. Prophylaxis means the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.
27. Qualified Grantee means an entity that can demonstrate that it can provide or Arrange For the provision of Covered Dental Care Services and may include but is not limited to:
 - a. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2020);
 - b. A community-based organization or foundation;
 - c. A Federally Qualified Health Center, safety-net clinic, or health district;
 - d. A local public health agency; or

- e. A private dental practice.
- 28. Qualified Provider means a licensed dentist or dental hygienist in good standing in Colorado or a person who employs a licensed dentist or dental hygienist in good standing in Colorado and who is willing to accept reimbursement for Covered Dental Services. A Qualified Provider may also be a Qualified Grantee if the person meets the qualifications of a Qualified Grantee.
- 29. Removable Prosthesis means complete or partial Dental Prosthesis, which after an initial fitting by a dentist, can be removed and reinserted by the eligible senior.
- 30. Restorative Services means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic needs of the client.
- 31. Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2020).

8.960.B Legal Basis

- 8.960.B.1 The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S. (2020).

8.960.C Request of Grant Proposals and Grant Award Procedures

8.960.C.1. Request for Grant Proposals

- 8.960.C.1.a Grant awards shall be made through an application process. The request for grant proposals form shall be issued by the Department and posted for public access on the Department's website at <https://www.colorado.gov/hcpf/research-data-and-grants> at least 30 days prior to the due date.

8.960.C.2 Evaluation of Grant Proposals

- 8.960.C.2.a Proposals submitted for the Colorado Dental Health Care Program for Low-Income Seniors will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.
 - 1) 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.C.3 Grant Awards

- 8.960.C.3.a The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Colorado Dental Health Care Program for Low-Income Seniors.

8.960.C.4 Qualified Grantee Responsibilities

- 8.960.C.4.a A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:
- 1) Identify and outreach to Eligible Seniors and Qualified Providers;
 - 2) Demonstrate collaboration with community-based organizations;
 - 3) Ensure that Eligible Seniors receive Covered Dental Care Services efficiently without duplication of services;
 - 4) Maintain records of Eligible Seniors serviced, Covered Dental Care Services provided, and moneys spent for a minimum of six (6) years;
 - 5) For Eligible Seniors with dental coverage through a Medicare Advantage Plan, bill the Medicare Advantage Plan for dental procedures covered by the Medicare Advantage Plan prior to seeking payment from the Department. The Colorado Dental Health Care Program is secondary to the Medicare Advantage Plan dental coverage;
 - 6) Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;
 - 7) Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and
 - 8) Submit an annual report as specified under section 8.960.3.F.

8.960.C.5 Invoicing

- 8.960.C.5.a A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors shall submit invoices on a form and schedule specified by the Department. Covered Dental Care Services shall be provided before a Qualified Grantee may submit an invoice to the Department.
- 1) Invoices shall include the number of Eligible Seniors served, the alphanumeric code and procedure description as listed in Appendix A, and any other information required by the Department.
 - 2) The Department will pay no more than the established Program Payment per procedure rendered, as listed in Appendix A.
 - 3) Eligible Seniors shall not be charged more than the Max Client Co-Pay as listed in Appendix A.

- 4) Qualified Grantees shall not bill the Department for any procedures covered by Medicare Advantage Plans that have been billed and paid by the Medicare Advantage Plans;
- 5) Qualified Grantees shall indicate on the invoice if the Eligible Senior has dental coverage through a Medicare Advantage Plan and any claim to the Medicare Advantage Plan was adjudicated prior to billing the Department;
- 6) Qualified Grantees may invoice for no more than seven (7) percent of the Program Payment for administrative costs.

8.960.C.6 Annual Report

8.960.C.6.a On or before September 1, 2016, and each September 1 thereafter, each Qualified Grantee receiving funds from the Colorado Dental Health Care Program for Low-Income Seniors shall submit a report to the Department following the state fiscal year contract period.

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

- 1) The number of Eligible Seniors served;
- 2) The types of Covered Dental Care Services provided;
- 3) An itemization of administrative expenditures;
- 4) The procedures and amounts billed to Medicare Advantage Plans for Eligible Seniors; and
- 5) Any other information deemed relevant by the Department.

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

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Limited oral evaluation - problem focused	D0140	\$63.14 62.00	\$53.14 52.00	\$10.00	This code must be used in association with a specific oral health problem or complaint and is not to be used to address situations that arise during multi-visit treatments covered by a single fee, such as, endodontic or post-operative visits related to treatments including prosthesis. Specific problems may include dental emergencies, trauma, acute infections, etc. Cannot be used for adjustments made to prosthesis provided within previous 6 months. Cannot be used as an encounter fee. Frequency: Two of D0140 per year per grantee. Not reimbursable on the same date as D0120 or D0150. Dental hygienists may only provide for an established client of record.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive oral evaluation - new or established client	D0150	\$81.00	\$81.00	\$0.00	<p>Evaluation used by general dentist or a specialist when evaluating a client comprehensively. Applicable to new clients; established clients with significant health changes or other unusual circumstances; or established clients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, and an evaluation and recording of the client's dental and medical history and general health assessment. A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0180.</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive periodontal evaluation - new or established client	D0180	\$88.00	\$88.00	\$0.00	Evaluation for clients presenting signs & symptoms of periodontal disease & clients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the client's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0150.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - comprehensive series of radiographic images	D0210	\$125.00	\$125.00	\$0.00	Radiographic survey of whole mouth, intended to display the crowns & roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. Panoramic radiographic image & bitewing radiographic images taken on the same date of service shall not be billed as a D0210. Payment for additional periapical radiographs within 60 days of a full month series or a panoramic film is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per client. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 must be billed and reimbursed as D0210. Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.
Intraoral - periapical first radiographic image	D0220	\$25.00	\$25.00	\$0.00	Six of D0220 per 12 months per client. Report additional radiographs as D0230. Working and final endodontic treatment films are not covered. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - periapical each additional radiographic image	D0230	\$23.00	\$23.00	\$0.00	D0230 must be utilized for additional films taken beyond D0220. Working and final endodontic treatment films are included in the endo codes. Not covered if billed with D3310, D3320, or D3330. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewing - single radiographic image	D0270	\$26. 5200	\$26. 5200	\$0.00	Frequency: 1 in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - two radiographic images	D0272	\$42.00	\$42.00	\$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - three radiographic images	D0273	\$52.00	\$52.00	\$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - four radiographic images	D0274	\$60.00	\$60.00	\$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Vertical bitewings – seven to eight radiographic images	D0277	\$68.32	\$68.32	\$0.00	Frequency: 1 time in a 12-month period. Counts as an intraoral complete series. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Panoramic radiographic image	D0330	\$63.00	\$63.00	\$0.00	Frequency: 1 per 5 years per client. Cannot be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 years.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Prophylaxis - adult	D1110	\$97.5088.00	\$97.5088.00	\$0.00	<p>Removal of plaque, calculus and stains from the tooth structures with intent to control local irritational factors. Frequency:</p> <ul style="list-style-type: none"> 1 time per 6 calendar months; 2 week window accepted. May be billed for routine prophylaxis. D1110 may be billed with D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth not receiving nonsurgical periodontal therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease. D1110 can only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed. May be alternated with D4910 for maintenance of periodontally-involved individuals. D1110 cannot be billed on the same day as D4346 Cannot be used as 1 month re-evaluation following nonsurgical periodontal therapy.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Topical application of fluoride varnish	D1206	\$52.00	\$52.00	\$0.00	Topical fluoride application is to be used in conjunction with prophylaxis or preventive appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. Cannot be used with D1208.
Topical application of fluoride - excluding varnish	D1208	\$52.00	\$52.00	\$0.00	Any fluoride application, including swishing, trays or paint on variety, to be used in conjunction with prophylaxis or preventive appointment. Frequency: one (1) time per 12 calendar months. Cannot be used with D1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
Application of caries arresting medicament – per tooth	D1354	\$ 54.53-88	\$ 54.53-88	\$0.00	Two of D1354 per 12 months per patient per tooth for primary and permanent teeth. Not to exceed 4 times per tooth in a lifetime. Cannot be billed on the same day as D1355 or any D2000 series code (D2140–D2954). Must Report tooth number.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Caries preventive medicament application – per tooth	D1355	\$5. 7463	\$5. 7463	\$0.00	For primary prevention or remineralization. Medicaments applied do not include topical fluorides. Medicaments that may be applied during the delivery of D1355 procedure include Silver Diamine Fluoride (SDF), Silver Nitrate (SN), thymol-CHX varnish, and topical povidone iodine (PVP-I). Cannot be billed on the same day as: D1206, D1208, D1354, D0140, D9110, or any restoration codes on the same day or within 12 months of D2140 thru D2954. Maximum of four D1355 per tooth per lifetime. Must report tooth number.
Amalgam Restorations (including polishing): Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).					
Amalgam - one surface, primary or permanent	D2140	\$1 20.0217.86	\$1 10.0207.86	\$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - two surfaces, primary or permanent	D2150	\$1 50.5947.83	\$1 40.5937.83	\$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - three surfaces, primary or permanent	D2160	\$1 82.4079.02	\$1 72.4069.02	\$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - four or more surfaces, primary or permanent	D2161	\$21 8.934.83	\$20 8.934.83	\$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-Based Composite Restorations – Direct: Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases, and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).					

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Resin-based composite - one surface, anterior	D2330	\$11 6.825.00	\$10 6.825.00	\$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - two surfaces, anterior	D2331	\$146.00	\$136.00	\$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	\$179.00	\$169.00	\$10.00	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	Incisal angle to be defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, posterior	D2391	\$134.00	\$124.00	\$10.00	Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite -two surfaces, posterior	D2392	\$176.00	\$166.00	\$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	\$218.00	\$208.00	\$10.00	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	Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - porcelain/ceramic	D2740	\$899.16 780.00	\$849.16 730.00	\$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to high noble metal	D2750	\$891.06 780.00	\$841.06 730.00	\$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to predominantly base metal	D2751	\$817.03 780.00	\$767.03 30.00	\$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to noble metal	D2752	\$848.29 780.00	\$798.29 30.00	\$50.00	Only one the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - 3/4 cast predominantly base metal	D2781	\$780.00	\$730.00	\$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 cast noble metal	D2782	\$780.00	\$730.00	\$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 porcelain/ceramic	D2783	\$780.00	\$730.00	\$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast high noble metal	D2790	\$918.62 780.00	\$868.62 730.00	\$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - full cast predominantly base metal	D2791	\$780.00	\$730.00	\$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast noble metal	D2792	\$780.00	\$730.00	\$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - titanium	D2794	\$886.88 780.00	\$836.88 730.00	\$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	\$87.00	\$77.00	\$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	\$89.00	\$79.00	\$10.00	Not allowed within 6 months of placement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Core buildup, including any pins when required	D2950	\$225.00	\$200.00	\$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of coronal structure when there is insufficient retention for a separate extracoronar restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. Not payable on the same tooth and same day as D2951.
Pin retention per tooth	D2951	\$50.00	\$40.00	\$10.00	Pins placed to aid in retention of restoration. Can only be used in combination with a multi-surface amalgam.
Cast post and core in addition to crown	D2952	\$332.00	\$307.00	\$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Prefabricated post and core in addition to crown	D2954	\$269.00	\$244.00	\$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Core is built around a prefabricated post. This procedure includes the core material and refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care) Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy; pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.					

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	\$849.76 566.40	\$799.76 546.40	\$50.00	Frequency: One D3310 per lifetime per client per tooth. Teeth covered: 6-11 and 22-27.
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	\$967.71 661.65	\$917.71 641.65	\$50.00	Frequency: One D3320 per lifetime per client per tooth. Teeth covered: 4, 5, 12, 13, 20, 21, 28, and 29.
Endodontic therapy, molar tooth (excluding final restoration)	D3330	\$1,159.31 786.34	\$1,109.31 736.34	\$50.00	Frequency: One D3330 per lifetime per client per tooth. Teeth covered: 2, 3, 14, 15, 18, 19, 30, and 31.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	\$276.51 477.00	\$266.51 467.00	\$10.00	<p>Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in others. Frequency:</p> <ul style="list-style-type: none"> • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	\$1 89.6828.00	\$1 89.6828.00	\$0.00	<p>Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency:</p> <ul style="list-style-type: none"> 1 time per quadrant per 36 month interval. No more than 2 quadrants may be considered in a single visit in a non-hospital setting.. Documentation of other treatment provided at same time will be requested. Cannot be charged on same date as D4346. Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	D4346	\$102.00	\$92.00	\$10.00	<p>The removal of plaque, calculus, and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures. Frequency: once in a lifetime.</p> <ul style="list-style-type: none"> Any follow-up and re-evaluation are included in the initial reimbursement. Cannot be charged on the same date as D1110, D4341, D4342, or D4910.
Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	D4355	\$100.0498.27	\$90.0488.27	\$10.00	<p>One of (D4335) per 3 year(s) per patient. Prophylaxis D1110 is not reimbursable when provided on the same day of service as D4355. D4355 is not reimbursable if patient record indicates D1110 or D4910 have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as D4355.</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal maintenance procedures	D4910	\$1 49.0136.00	\$1 49.0136.00	\$0.00	<p>Procedure following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. Frequency:</p> <ul style="list-style-type: none"> • Up to four times per fiscal year per client. • Cannot be charged on the same date as D4346. • Cannot be charged within the first three months following active periodontal treatment.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - maxillary	D5110	\$931.41 144.72	\$851.41 134.72	\$80.00	Reimbursement made upon delivery of a complete maxillary denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130 or D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	\$9 32.94 16.22	\$8 52.94 36.22	\$80.00	Reimbursement made upon delivery of a complete mandibular denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130, D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – maxillary	D5130	\$9 31.41 <u>14.72</u>	\$8 51.41 <u>34.72</u>	\$80.00	Reimbursement made upon delivery of an immediate maxillary denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5130 can be reimbursed only once per lifetime per client. Complete denture, D5110, may be considered 5 years after immediate denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – mandibular	D5140	\$9 32.94 16.22	\$8 52.94 36.22	\$80.00	Reimbursement made upon delivery of an immediate mandibular denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5140 can be reimbursed only once per lifetime per client. Complete dentures, D5120, may be considered 5 years after immediate denture was reimbursed – documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213	\$900.48 884.00	\$840.48 24.00	\$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 healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	\$900.48 884.00	\$840.48 24.00	\$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 serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	D5221	\$ 646.83 <u>35.32</u>	\$ 586.83 <u>75.32</u>	\$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5221 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	D5222	\$ 646.83 <u>35.32</u>	\$ 586.83 <u>75.32</u>	\$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5222 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5223	\$900.48 884.00	\$840.48 24.00	\$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 be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5224	\$900.48 884.00	\$840.48 24.00	\$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 be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – flexible base (including retentive/clasping rests, and teeth)	D5225	\$7 98.83 84.34	\$7 38.83 24.34	\$60.00	Reimbursement made upon delivery of a partial maxillary denture to the client. D5225 and D5226 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial flexible base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial flexible base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every three years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5226	\$ 798.83 84.34	\$ 738.83 24.34	\$60.00	Reimbursement made upon delivery of a partial mandibular denture to the client. D5225 and D5226 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial flexible base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial flexible base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every three years - documentation that existing prosthesis cannot be made serviceable must be maintained.
Repair broken complete denture base, mandibular	D5511	\$ 131.84 29.45	\$ 121.84 19.45	\$10.00	Repair broken complete mandibular denture base. Frequency: two of D5511 per 12 months per client.
Repair broken complete denture base, maxillary	D5512	\$ 131.84 29.45	\$ 121.84 19.45	\$10.00	Repair broken complete maxillary denture base. Frequency: two of D5512 per 12 months per client.
Replace missing or broken teeth - complete denture (each tooth)	D5520	\$ 98.85 7.11	\$ 88.85 7.11	\$10.00	Replacement/repair of missing or broken teeth. Teeth 1 – 32 and must report tooth number.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Repair resin partial denture base, mandibular	D5611	\$9 9.557.79	\$8 9.557.79	\$10.00	Repair resin partial mandibular denture base. Frequency: two D5611 per 12 months per client.
Repair resin partial denture base, maxillary	D5612	\$9 9.557.79	\$8 9.557.79	\$10.00	Repair resin partial maxillary denture base. Frequency: two D5612 per 12 months per client.
Repair cast partial framework, mandibular	D5621	\$12 9.276.93	\$11 9.276.93	\$10.00	Repair cast partial mandibular framework. Frequency: two D5621 per 12 months per client.
Repair cast partial framework, maxillary	D5622	\$12 9.276.93	\$11 9.276.93	\$10.00	Repair cast partial maxillary framework. Frequency: Two D5622 per 12 months per client.
Repair or replace broken retentive/clasping materials – per tooth	D5630	\$13 9.667.12	\$12 9.667.12	\$10.00	Repair of broken clasp on partial denture base – per tooth. Teeth 1 – 32, report tooth number(s).
Replace broken teeth-per tooth	D5640	\$ 100.0498.27	\$ 90.0488.27	\$10.00	Repair/replacement of missing tooth. Teeth 1 – 32, report tooth number(s).
Add tooth to existing partial denture	D5650	\$109.00	\$99.00	\$10.00	Adding tooth to partial denture base. Documentation may be requested when charged on partial delivered in last 12 months. Teeth 1 – 32, report tooth number(s).
Add clasp to existing partial denture	D5660	\$14 5.082.43	\$13 5.082.43	\$10.00	Adding clasp to partial denture base – per tooth. Documentation may be requested when charged on partial delivered in last 12 months. Teeth 1 – 32, report tooth number(s).
Rebase complete maxillary denture	D5710	\$322.00	\$297.00	\$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Rebase complete mandibular denture	D5711	\$322.00	\$297.00	\$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase maxillary partial denture	D5720	\$304.00	\$279.00	\$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase mandibular partial denture	D5721	\$304.00	\$279.00	\$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Reline complete maxillary denture (chairside)	D5730	\$1 90.0886.55	\$1 80.0876.55	\$10.00	Frequency: One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (chairside)	D5731	\$1 90.0886.55	\$1 80.0876.55	\$10.00	Frequency: One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (chairside)	D5740	\$18 7.694.21	\$17 7.694.21	\$10.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Reline mandibular partial denture (chairside)	D5741	\$18 9.495.97	\$17 9.495.97	\$10.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete maxillary denture (laboratory)	D5750	\$2 53.1348.66	\$22 8.133.66	\$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (laboratory)	D5751	\$2 54.3149.81	\$22 9.314.81	\$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (laboratory)	D5760	\$2 51.3346.89	\$22 6.334.89	\$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (laboratory)	D5761	\$2 51.3346.89	\$22 6.334.89	\$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	\$11 9.076.93	\$10 9.076.93	\$10.00	Removal of tooth structure, minor smoothing of socket bone, and closure as necessary. Frequency: One D7140 per lifetime per client per tooth. Teeth 1 – 32.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	\$18 4.541.12	\$17 4.541.12	\$10.00	Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure. Frequency: One of D7210 per lifetime per client per tooth. Teeth 1 - 32
Removal of impacted tooth-soft tissue	D7220	\$2 20.6616.73	\$ 200.66196.73	\$20.00	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32. Frequency: One of D7220 per 1 lifetime per client per tooth.
Removal of impacted tooth-partially bony	D7230	\$2 72.4067.45	\$2 52.4047.45	\$20.00	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7230 per 1 lifetime per patient per tooth
Removal of impacted tooth-completely bony	D7240	\$31 6.180.37	\$29 6.180.37	\$20.00	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7240 per 1 lifetime per patient per tooth.
Removal of impacted tooth-completely bony, with unusual surgical complications	D7241	\$4 15.6407.88	\$3 95.6487.88	\$20.00	Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Teeth 1-32. Frequency: One of D7241 per lifetime per patient per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of residual tooth roots (cutting procedure)	D7250	\$19 4.641.02	\$18 4.641.02	\$10.00	Includes cutting of soft tissue and bone, removal of tooth structure, and closure. Cannot be charged for removal of broken off roots for recently extracted tooth. Teeth 1 – 32 Frequency: One D7250 per lifetime per patient per tooth.
Primary closure of a sinus perforation	D7261	\$4 85.3576.03	\$4 75.3566.03	\$10.00	Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oronasal communication in absence of fistulous tract. Narrative of medical necessity may be required and if the sinus perforation was caused by a current grantee or provider of the program.
<u>Incisional biopsy of oral tissue - hard (bone, tooth)</u>	<u>D7285</u>	<u>\$193.01</u>	<u>\$183.01</u>	<u>\$10.00</u>	<u>For partial removal of specimen only. This procedure involves biopsy of osseous lesions and is not used for apicectomy/periradicular surgery. This procedure does not entail an excision. Only covered if there is a suspicious lesion. Must have a pathology report in file.</u>
Incisional biopsy of oral tissue-soft	D7286	\$3 9184.00	\$381.00	\$ 100.00	For partial removal of an architecturally intact specimen only. D7286 is not used at the same time as codes for apicoectomy/periradicular curettage and does not entail an excision. Treatment notes must include documentation and proof that biopsy was sent for evaluation.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max 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	D7310 is distinct (separate procedure) from extractions. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One D7310 or D7311 per lifetime per patient per quadrant. Reported per quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	\$14 8.695.97	\$13 8.695.97	\$10.00	D7311 is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One D7311 or D7310 per lifetime per patient per quadrant. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	\$21 4.110.11	\$20 4.110.11	\$10.00	No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant. Reported per quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	\$21 4.110.11	\$20 4.110.11	\$10.00	No extractions performed in an edentulous area. See D7311 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant. Reported per quadrant.
<u>Excision of benign Lesion up to 1.25 cm</u>	<u>D7410</u>	<u>\$197.16</u>	<u>\$187.16</u>	<u>\$10.00</u>	<u>Must have a pathology report in file.</u>
<u>Removal of benign nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm</u>	<u>D7460</u>	<u>\$248.70</u>	<u>\$238.70</u>	<u>\$10.00</u>	<u>Must have a pathology report in file.</u>
Removal of lateral exostosis (maxilla or mandible)	D7471	\$3 10.1704.28	\$ 300.17294.28	\$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Reported per arch (LA or UA)
Removal of torus palatinus	D7472	\$3 64.7957.83	\$ 354.7947.83	\$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Must list quadrant.
Removal of torus mandibularis	D7473	\$3 55.7949.04	\$ 345.7939.04	\$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Must list quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Incision & drainage of abscess - intraoral soft tissue	D7510	\$19 6.663.00	\$18 6.663.00	\$10.00	Incision through mucosa, including periodontal origins. One of D7510 per lifetime per client per tooth. Report per tooth.
Palliative treatment of dental pain – per visit	D9110	\$8 2.040.92	\$5 7.045.92	\$25.00	Emergency treatment to alleviate pain/discomfort. This code cannot be used for filing claims or writing or calling in a prescription to the pharmacy or to address situations that arise during multi-visit treatments covered by a single fee such as surgical or endodontic treatment. Report per visit, no procedure. Frequency: Limit 1 time per year. Maintain documentation that specifies problem and treatment.
Evaluation for moderate sedation, deep sedation or general anesthesia	D9219	\$4 3.832.97	\$4 3.832.97	\$0.00	One of D9219 or D9310 per 12 month(s) per grantee
Deep sedation/general anesthesia-each 15 minute increment	D9223	\$1 10.0908.13	\$ 100.0998.13	\$10.00	Nine of D9223 per 1 day per patient. Not allowed with D9243
Intravenous moderate (conscious) sedation/analgesia-first 15 minutes	D9239	\$12 4.762.54	\$11 4.762.54	\$10.00	One of D9239 per 1 day per patient.
Intravenous moderate (conscious) sedation/analgesia-each 15 minute increment	D9243	\$1 10.0908.13	\$ 100.0998.13	\$10.00	Thirteen of D9243 per 1 day per patient. Not allowed with D9223

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

Mesial, Distal, Occlusal, Lingual, or Buccal	2	Placed, without interruption, on two of the surface classifications.
	3	Placed, without interruption, on three of the surface classifications.
	4 or more	Placed, without interruption, on four or more of the surface classifications.

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

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