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Title of Rule: Revision to the MA Rule Concerning Dental Health Care Program for Low-Income Seniors, Procedure Rate Increase on Schedule A for Fiscal Year 2025-26.
Rule Number: MSB 25-05-07-A
Special Financing / Alondra Yanez / 303-866-6536

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 25-05-07-A, Revision to the MA Rule Concerning Dental Health Care Program for Low-Income Seniors, Procedure Rate Increase on Schedule A for Fiscal Year 2025-26.
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) 25.5-1-301 through 25.5-1-303, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10). 10 CCR 2505-10 § 8.960 Schedule A, table columns labeled Max Allowable Fee and Program Payment.
5. Does this action involve any temporary or emergency rule(s)? Yes
If yes, state effective date: 7/1/2025
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.960.A with the proposed language beginning at 8.960.A.6 through the end of 8.960.C.5.a.3. Replace the current text at 8.960 Appendix A with the proposed text beginning at 8.960 Appendix A through the end of 8.960 Appendix A. This rule is effective July 1, 2025.

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STATEMENT OF BASIS AND PURPOSE

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

Senior Dental Program statute 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, 2025, many procedures will fall below the base Medicaid dental rates. This change is necessary to stay in compliance with rule.

2. An emergency rule-making is imperatively necessary

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

Explain:

Senior Dental Program statute states that no program max rates will be below Medicaid dental rates, and the Medicaid dental rates will be increased as of July 1, 2025.

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);
Sections 25.5-3-401 through 25.5-3-406, C.R.S. (2024)

Initial Review
Proposed Effective Date

07/01/25

Final Adoption
Emergency Adoption

06/13/25
DOCUMENT #

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REGULATORY ANALYSIS

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

The increase in program rates will not affect any classes and there will be no incurred costs for any classes. Senior Dental Program grantees will benefit by the 1.6% increase in rates, keeping their payments set to no less than Medicaid rates for the same procedure codes.

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 as the Senior Dental Program is funded through an appropriation of general fund dollars, the amount of which will not change based on this rule update. The benefits will be for the Department to be in compliance with the Senior Dental Program 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.

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

There are no alternative methods for staying in compliance with the Senior Dental Program 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 ~~Schedule~~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~~patient 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~~patient 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 ~~ScheduleAppendix~~ A. The Max Allowable Fee is the sum of the Program Payment and the Max ~~ClientPatient~~ Co-Pay.

16. Max ~~ClientPatient~~ Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure in ~~ScheduleAppendix~~ 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, s~~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 ~~clientpatient~~ 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 ~~ScheduleAppendix~~ 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/patient.

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 ~~Schedule~~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 ~~Schedule~~Appendix A.
- 3) Eligible Seniors shall not be charged more than the Max ~~Client~~Patient Co-Pay as listed in ~~Schedule~~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 ~~SCHEDULE~~APPENDIX A: COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS COVERED SERVICES AND PROCEDURE CODES

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadra nt Covered	PROGRAM GUIDELINES
Periodic oral evaluation established - client patient	D0120	\$46.00	\$46.00	\$0.00		Evaluation performed on a client patient of record to determine any changes in the client patient'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 patient. Report additional diagnostic procedures separately. Frequency: One time per 6 month period per client. Two of D0120, D0150, D0180 per 12 months per patient.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client <u>Patient</u> Co-Pay	<u>Teeth or</u> <u>Quadrant</u> <u>Covered</u>	PROGRAM GUIDELINES
Limited oral evaluation - problem focused	D0140	\$63. 44 <u>99</u>	\$53. 44 <u>99</u>	\$10.00		<p>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. An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.</p> <p>Frequency: Two of D0140 per year<u>12 months</u> per grantee <u>per patient</u>. Not reimbursable on the same date as D0120, or D0150, <u>or D0180</u>. Dental hygienists may only provide for an established client<u>patient</u> of record.</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadra nt Covered	PROGRAM GUIDELINES
Comprehensive oral evaluation - new or established client <u>patient</u>	D0150	\$81.00	\$81.00	\$0.00		<p>Evaluation used by general dentist <u>and/or</u> a specialist when evaluating a client<u>patient</u> comprehensively. Applicable to new clients<u>patients</u>; established clients<u>patients</u> with significant health changes or other unusual circumstances <u>by report</u>; or established clients<u>patients</u> 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. <u>It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This includes an evaluation for oral cancer, the</u> and an evaluation and recording of the client<u>patient</u>'s dental and medical history and general health assessment. <u>A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included.</u> It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, <u>periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.</u> Frequency: <u>1 per 3 years per client. Cannot be charged on the same date as D0180. One of D0150 per 36 months per grantee per patient. Two of D0120, D0150, D0180 per 12 months per grantee per patient.</u></p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Comprehensive periodontal evaluation - new or established client patient	D0180	\$88.00	\$88.00	\$0.00		Evaluation for clients presenting This procedure is indicated for patients showing signs & symptoms of periodontal disease & clients patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, <u>an evaluation for oral cancer</u> , evaluation and recording of the client patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, <u>and</u> occlusal relationships and oral cancer evaluation . Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0150. One of D0180 per 36 months per patient. Two of D0120, D0150, D0180 per 12 months per patient.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	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 <u>D0330</u> & bitewing radiographic images <u>D0270-D0277</u> taken on the same date of service shall not be billed as a D0210. <u>Minimum of 12-20 films is required.</u> Payment for additional periapical radiographs within 60 days of a full month <u>mouth</u> series <u>D0277</u> or a panoramic film <u>D0330</u> is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per client. <u>One of D0210, D0277, D0330 per 60 months per patient.</u> 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 radiographic image - first	D0220	\$25.00	\$25.00	\$0.00		Six of D0220 per 12 months per client <u>patient</u> . Report additional radiographs as D0230. Working and final endodontic treatment films are not covered. <u>Not covered if billed with D3310, D3320, D3330.</u> 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. <u>Not allowed on the same day as D0210.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	<u>Teeth or Quadrant Covered</u>	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. <u>Not allowed on the same day as D0210.</u> 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	\$26.52	\$26.52	\$0.00		Frequency: 1 in a 12 month period. <u>One of D0270, D0272, D0273, D0274 per 12 months per patient.</u> 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. <u>One of D0270, D0272, D0273, D0274 per 12 months per patient.</u> 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. <u>One of D0270, D0272, D0273, D0274 per 12 months per patient.</u> 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. <u>One of D0270, D0272, D0273, D0274 per 12 months per patient.</u> 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 Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Vertical bitewings – seven to eight radiographic images	D0277	\$68.32	\$68.32	\$0.00		Frequency: 1 time in a 12-month period. One of D0210, D0277, D0330 per 60 months per patient. Counts as a full mouth series. Counts as an intraoral complete series. 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. One of D0210, D0277, D0330 per 60 months per grantee per patient. Counts as a full mouth series. 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 <u>Patient</u> Co-Pay	<u>Teeth or</u> <u>Quadra</u> <u>nt</u> <u>Covered</u>	PROGRAM GUIDELINES
Prophylaxis - adult	D1110	\$97.50 <u>99.06</u>	\$97.50 <u>99.06</u>	\$0.00		<p>Removal of plaque, calculus and stains from the tooth structures <u>and implants in the permanent and transitional dentition. It is intended—with intent</u> to control local irritational factors. Frequency:</p> <ul style="list-style-type: none"> 4 time per 6 calendar months; 2 week window accepted.<u>Two of D1110, D4346, D4910 per 12 months per patient.</u> 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<u>D4341 – D4910.</u> Cannot be used as 1 month re-evaluation following nonsurgical periodontal therapy.<u>Only allowed for cases with a history of surgical or non-surgical periodontal treatment, excluding D4355.</u>
Topical application of fluoride varnish	D1206	\$52.00	\$52.00	\$0.00		<p>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.</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	<u>Teeth or</u> <u>Quadrant</u> <u>Covered</u>	PROGRAM GUIDELINES
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 <u>55.40</u>	\$54.53 <u>55.40</u>	\$0.00	<u>Teeth 1-32</u>	<u>Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure. Frequency:</u> 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 <u>or D3110 or D3120</u> or any D2000 series code (D2140–D2954). Must Report tooth number.
Caries preventive medicament application – per tooth	D1355	\$5.74 <u>83</u>	\$5.74 <u>83</u>	\$0.00	<u>Teeth 1-32</u>	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 - one surface, primary or permanent	D2140	\$120.02 <u>121.78</u>	\$110.02 <u>11.78</u>	\$10.00	<u>Teeth 1-32</u>	Frequency: 36 months for the same restoration. <u>See Explanation of Restorations. One of D2140 – D2394 per 36 months per patient per tooth per surface.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Amalgam - two surfaces, primary or permanent	D2150	\$150.59 15 <u>2.84</u>	\$140.59 1 <u>42.84</u>	\$10.00	Teeth 1-32	Frequency: 36 months for the same restoration. See Explanation of Restorations. One of D2140 – D2394 per 36 months per patient per tooth per surface.
Amalgam - three surfaces, primary or permanent	D2160	\$182.40 18 <u>5.16</u>	\$172.40 1 <u>75.16</u>	\$10.00	Teeth 1-32	Frequency: 36 months for the same restoration. See Explanation of Restorations. One of D2140 – D2394 per 36 months per patient per tooth per surface.
Amalgam - four or more surfaces, primary or permanent	D2161	\$218.93 22 <u>2.27</u>	\$208.93 2 <u>12.27</u>	\$10.00	Teeth 1-32	Frequency: 36 months for the same restoration. See Explanation of Restorations. One of D2140 – D2394 per 36 months per patient per tooth per surface.
Resin-based composite - one surface, anterior	D2330	\$116.82 11 <u>8.53</u>	\$106.82 1 <u>08.53</u>	\$10.00	Teeth 6 - 11, 22 - 27	Frequency: 36 months for the same restoration. One of D2140 – D2394 per 36 months per patient per tooth per surface. See Explanation of Restorations.
Resin-based composite - two surfaces, anterior	D2331	\$146.00	\$136.00	\$10.00	Teeth 6 - 11, 22 - 27	Frequency: 36 months for the same restoration. One of D2140 – D2394 per 36 months per patient per tooth per surface. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	\$179.00	\$169.00	\$10.00	Teeth 6 - 11, 22 - 27	Frequency: 36 months for the same restoration. One of D2140 – D2394 per 36 months per patient per tooth per surface. See Explanation of Restorations.
Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	\$212.00	\$202.00	\$10.00	Teeth 6 - 11, 22 - 27	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. One of D2140 – D2394 per 36 months per patient per tooth per surface. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Resin-based composite - one surface, posterior	D2391	\$134.00	\$124.00	\$10.00	<u>Teeth 1 - 5, 12 - 21, 28 - 32</u>	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. <u>One of D2140 - D2394 per 36 months per patient per tooth per surface.</u> See Explanation of Restorations.
Resin-based composite -two surfaces, posterior	D2392	\$176.00	\$166.00	\$10.00	<u>Teeth 1 - 5, 12 - 21, 28 - 32</u>	Frequency: 36 months for the same restoration. <u>One of D2140 - D2394 per 36 months per patient per tooth per surface.</u> See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	\$218.00	\$208.00	\$10.00	<u>Teeth 1 - 5, 12 - 21, 28 - 32</u>	Frequency: 36 months for the same restoration. <u>One of D2140 - D2394 per 36 months per patient per tooth per surface.</u> See Explanation of Restorations.
Resin-based composite - four or more surfaces, posterior	D2394	\$268.00	\$258.00	\$10.00	<u>Teeth 1 - 5, 12 - 21, 28 - 32</u>	Frequency: 36 months for the same restoration. <u>One of D2140 - D2394 per 36 months per patient per tooth per surface.</u> See Explanation of Restorations.
Crown - porcelain/ceramic	D2740	\$899.16 <u>912.75</u>	\$849.16 <u>82.75</u>	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	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. Frequency: One of D2740 - D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Crown - porcelain fused to high noble metal	D2750	\$891.06 <u>904.52</u>	\$841.06 <u>854.52</u>	\$50.00	Teeth 2 - 15, 18 - 31	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. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to predominantly base metal	D2751	\$817.03 <u>829.30</u>	\$767.03 <u>779.30</u>	\$50.00	Teeth 2 - 15, 18 - 31	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. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to noble metal	D2752	\$848.29 <u>861.06</u>	\$798.29 <u>811.06</u>	\$50.00	Teeth 2 - 15, 18 - 31	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. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Crown - 3/4 cast predominantly base metal	D2781	\$780.00	\$730.00	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	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. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 cast noble metal	D2782	\$780.00	\$730.00	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	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. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 porcelain/ceramic	D2783	\$780.00	\$730.00	\$50.00	<u>Teeth 1 - 32</u>	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. This procedure does not include facial veneers. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Crown - full cast high noble metal	D2790	\$918.62 932.52	\$868.62 82.52	\$50.00	Teeth 2 - 15, 18 - 31	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. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast predominantly base metal	D2791	\$780.00	\$730.00	\$50.00	Teeth 2 - 15, 18 - 31	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. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast noble metal	D2792	\$780.00	\$730.00	\$50.00	Teeth 2 - 15, 18 - 31	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. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Crown - titanium <u>and titanium alloys</u>	D2794	\$886.88 90.27	\$836.88 50.27	\$50.00	<u>Teeth 2 - 15, 18 - 31</u>	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. Frequency: One of D2740 – D2794 per 84 months per patient per tooth. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	\$87.00	\$77.00	\$10.00	<u>Teeth 1 - 32</u>	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	\$89.00	\$79.00	\$10.00	<u>Teeth 1 - 32</u>	Not allowed within 6 months of placement.
<u>Placement of Interim Direct Restoration</u>	<u>D2940</u>	\$65.21 66.09	\$55.21 56.09	<u>\$10.00</u>	<u>Teeth 1 - 32</u>	<u>Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, manage caries, create a seal for endodontic isolation, or prevent further deterioration until definitive treatment can be rendered. Not to be used for endodontic access closure, or as a base or liner under restoration. One of D2940 per lifetime per tooth. RDH's will receive reimbursement when used for telehealth dentistry in partnership with treating dentist.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Core buildup, including any pins when required	D2950	\$225.00	\$200.00	\$25.00	<u>Teeth 2 - 15, 18 - 31</u>	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. <u>Frequency: One of D2950, D2952, D2954 per 84 months per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed.</u> Not payable on the same tooth and same day as D2951.
Pin retention - per tooth, <u>in addition to restoration</u>	D2951	\$50.00	\$40.00	\$10.00	<u>Teeth 2 - 15, 18 - 31</u>	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, <u>indirectly fabricated</u>	D2952	\$332.00	\$307.00	\$25.00	<u>Teeth 2 - 15, 18 - 31</u>	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Post and core are custom fabricated as a single unit. <u>Frequency: One of D2950, D2952, D2954 per 84 months per patient per tooth.</u> 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	<u>Teeth 2 - 15, 18 - 31</u>	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. <u>Frequency: One of D2950, D2952, D2954 per 84 months per patient per tooth.</u> and <u>Refers to building up of anatomical crown when restorative crown will be placed.</u> Not payable on the same tooth and same day as D2951.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
<u>Application of Hydroxyapatite Regeneration Medicament - per tooth</u>	<u>D2991</u>	<u>\$66.3067. 20</u>	<u>\$56.3057 .20</u>	<u>\$10.00</u>	<u>Teeth 1 - 32</u>	<u>Preparation of tooth surfaces and topical application of a scaffold to guide hydroxyapatite regeneration. One of D2991 per lifetime per patient per tooth. Cannot be billed on the same day/same tooth as any other D2000's codes or D1354.</u>
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	<u>\$849.7686 2.56</u>	<u>\$799.768 12.56</u>	\$50.00	<u>Teeth 6 - 11, 22 - 27</u>	Frequency: One D3310 per lifetime per client patient per tooth. Teeth covered: 6-11 and 22-27.
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	<u>\$967.7198 2.39</u>	<u>\$917.719 32.39</u>	\$50.00	<u>Teeth 4, 5, 12, 13, 20, 21, 28, 29</u>	Frequency: One D3320 per lifetime per client patient per tooth. Teeth covered: 4, 5, 12, 13, 20, 21, 28, and 29.
Endodontic therapy, molar tooth (excluding final restoration)	D3330	<u>\$1,159.34 1,177.06</u>	<u>\$1,109.3 41,127.06</u>	\$50.00	<u>Teeth 2, 3, 14, 15, 18, 19, 30, 31</u>	Frequency: One D3330 per lifetime per client patient per tooth. <u>Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</u> Teeth covered: 2, 3, 14, 15, 18, 19, 30, and 31.
<u>Retreatment of Previous Root Canal Therapy- Anterior</u>	<u>D3346</u>	<u>\$976.20</u>	<u>\$926.20</u>	<u>\$50.00</u>	<u>Teeth 6 - 11, 22 - 27</u>	<u>Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. One of D3346 per lifetime per patient per tooth. Only reimbursable if original treatment not paid by Senior Dental Program.</u>
<u>Retreatment of Previous Root Canal Therapy- Premolar</u>	<u>D3347</u>	<u>\$1,110.83</u>	<u>\$1,060.8 3</u>	<u>\$50.00</u>	<u>Teeth 4, 5, 12, 13, 20, 21, 28, 29</u>	<u>Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. One of D3347 per lifetime per patient per tooth. Only reimbursable if original treatment not paid by Senior Dental Program</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
<u>Retreatment of Previous Root Canal Therapy-Molar</u>	<u>D3348</u>	<u>\$1,316.00</u>	<u>\$1,266.00</u>	<u>\$50.00</u>	<u>Teeth 2, 3, 14, 15, 18, 19, 30, 31</u>	<u>Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. One of D3348 per lifetime per patient per tooth. Only reimbursable if original treatment not paid by Senior Dental Program. Second molars are only covered if it meets criteria and is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	\$276.51 <u>280.77</u>	\$266.51 <u>70.77</u>	\$10.00	<u>Per Quadrant LL, LR, UL, or UR</u>	<p>†This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. <u>It is indicated for patients</u>For clients with periodontal disease and is therapeutic, not prophylactic, <u>in nature</u>. 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"> 4 time per quadrant per 36 month interval <u>One of D4341, D4342 per 36 months per patient per quadrant. A minimum of four affected teeth in the quadrant.</u> No more than 2 quadrants may be considered in a single visit <u>Maximum of two quadrants per date of service</u> in a non-hospital setting. Cannot be charged on same date as D4346 <u>D1110</u>. Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	\$189.68 <u>192.71</u>	\$189.68 <u>192.71</u>	\$0.00	<u>Per Quadrant LL, LR, UL, or UR</u>	<p>†This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clientsIt is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. 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 <u>others</u>. Current periodontal charting must be present in client<u>patient</u> chart documenting active periodontal disease. Frequency:</p> <ul style="list-style-type: none"> 1 time per quadrant per 36 month interval.One of D4341, D4342 per 36 months per patient per quadrant. A maximum of three teeth in the affected quadrant. No more than 2 quadrants may be considered in a single visit.Maximum of two quadrants per date of service in a non-hospital setting.. Documentation of other treatment provided at same time will be requested. Cannot be charged on same date as D4346<u>D1110</u>. Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	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. <u>Two of D1110, D4346 per 12 months per patient. Not reimbursed when billed on the same date of service as D1110, D4341, D4342, D4355, D4910.</u></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 <u>periodontal</u> evaluation and diagnosis on a subsequent visit	D4355	\$100.04 <u>101.48</u>	\$90.04 <u>91.48</u>	\$10.00		<p>One of (D4335) per 3-year(s)<u>36 months</u> per patient. Prophylaxis D0150, D0160, D0180 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 Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Periodontal maintenance procedures	D4910	\$149.04 151.39	\$149.04 151.39	\$0.00		<p>This procedure is instituted 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. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered. Frequency:</p> <ul style="list-style-type: none"> Up to four times per fiscal year per client patient. Cannot be charged on the same date as D4346. Cannot be charged within the first three months following active periodontal treatment.
Complete denture - maxillary	D5110	\$931.41 945.03	\$851.41 865.03	\$80.00		<p>Reimbursement made upon delivery of a complete maxillary denture to the client patient. D5110 or D5120 cannot be used to report an immediate denture, D5130 or D5140. Routine follow-up adjustments/reline 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 patient, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years 60 months - documentation that existing prosthesis cannot be made serviceable must be maintained.</p>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	\$932.94 <u>946.59</u>	\$852.948 <u>66.59</u>	\$80.00		Reimbursement made upon delivery of a complete mandibular denture to the client patient. D5110 or D5120 cannot be used to report an immediate denture, D5130, D5140. Routine follow-up adjustments/reline 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 patient, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years <u>60 months</u> - documentation that existing prosthesis cannot be made serviceable must be maintained.
Immediate denture maxillary	D5130	\$931.41 <u>945.03</u>	\$851.418 <u>65.03</u>	\$80.00		Reimbursement made upon delivery of an immediate maxillary denture to the client patient. 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 patient. Complete denture, D5110, may be considered 5 years <u>60 months</u> 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 Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Immediate denture mandibular –	D5140	\$932.94 <u>94.6.59</u>	\$852.94 <u>86.59</u>	\$80.00		Reimbursement made upon delivery of an immediate mandibular denture to the <u>client/patient</u> . 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 <u>client/patient</u> . Complete dentures, D5120, may be considered 5—years <u>60 months</u> 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 Patient Co-Pay	Teeth or Quadrant Covered	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 patient. 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 36 months - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client <u>Patient</u> Co-Pay	<u>Teeth or</u> <u>Quadrant</u> <u>Covered</u>	PROGRAM GUIDELINES
Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5212	\$778.00	\$718.00	\$60.00		Reimbursement made upon delivery of a complete partial mandibular denture to the client <u>patient</u> . D5211 and D5212 are considered definitive treatment. Routine follow-up adjustments/reline 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 <u>36 months</u> - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	<u>Teeth or Quadrant Covered</u>	PROGRAM GUIDELINES
Maxillary partial denture – cast metal framework with resin denture bases (including any—conventional clasps <u>retentive/clasping materials</u> , rests and teeth)	D5213	\$900.48 <u>913.93</u>	\$840.48 <u>853.93</u>	\$60.00		Reimbursement made upon delivery of a complete partial maxillary denture to the client <u>patient</u> . 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 <u>60 months</u> - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Mandibular partial denture – cast metal framework with resin denture bases (including any—conventional clasps retentive/clasping materials, rests and teeth)	D5214	\$900.48 913.93	\$840.48 53.93	\$60.00		Reimbursement made upon delivery of a complete partial mandibular denture to the client patient. 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 60 months - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Immediate maxillary partial denture – resin base (including any—conventional clasps retentive/clasping materials, rests and teeth)	D5221	\$646.83 65 <u>6.22</u>	\$586.83 5 <u>96.22</u>	\$60.00		Reimbursement made upon delivery of an immediate partial maxillary denture to the client patient. D5221 can be reimbursed only once per lifetime per client patient 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 <u>36 months</u> 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 Patient Co-Pay	Teeth or Quadra nt Covered	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including any—conventional clasps retentive/clasping materials, rests and teeth)	D5222	\$646-8365 <u>6.22</u>	\$586-835 <u>96.22</u>	\$60.00		Reimbursement made upon delivery of an immediate partial mandibular denture to the client patient. D5222 can be reimbursed only once per lifetime per client patient 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 <u>36 months</u> 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 Patient Co-Pay	<u>Teeth or</u> <u>Quadrant</u> <u>Covered</u>	PROGRAM GUIDELINES
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any—conventional clasps <u>retentive/clasping materials</u> , rests and teeth)	D5223	\$900.48 <u>913.93</u>	\$840.48 <u>8853.93</u>	\$60.00		Reimbursement made upon delivery of an immediate partial maxillary denture to the client <u>patient</u> . D5223 can be reimbursed only once per lifetime per client <u>patient</u> 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 <u>60 months</u> 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 Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any—conventional <u>clasps retentive/clasping materials</u> , rests and teeth)	D5224	\$900.48 <u>913.93</u>	\$840.488 <u>53.93</u>	\$60.00		Reimbursement made upon delivery of an immediate partial mandibular denture to the client <u>patient</u> . D5224 can be reimbursed only once per lifetime per client <u>patient</u> 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 <u>60 months</u> 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 Patient Co-Pay	Teeth or Quadra nt Covered	PROGRAM GUIDELINES
Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5225	\$798.83 <u>\$10.65</u>	\$738.83 <u>\$50.65</u>	\$60.00		Reimbursement made upon delivery of a partial maxillary denture to the client patient. 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 <u>36 months</u> - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadra nt Covered	PROGRAM GUIDELINES
Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5226	\$798.83 10.65	\$738.83 750.65	\$60.00		Reimbursement made upon delivery of a partial mandibular denture to the client patient. 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 36 months - documentation that existing prosthesis cannot be made serviceable must be maintained.
<u>Adjust Complete Denture - maxillary</u>	<u>D5410</u>	<u>\$54.4155.12</u>	<u>\$44.4145.12</u>	<u>\$10.00</u>		<u>Adjust complete maxillary denture. Frequency: two of D5410 per 12 months per client. Cannot be charged on a denture provided in last six months. Cannot be charged in addition to a rebase or reline in a 12 month period.</u>
<u>Adjust Complete Denture - mandibular</u>	<u>D5411</u>	<u>\$54.4155.12</u>	<u>\$44.4145.12</u>	<u>\$10.00</u>		<u>Adjust complete maxillary denture. Frequency: two of D5411 per 12 months per client. Cannot be charged on a denture provided in last six months. Cannot be charged in addition to a rebase or reline in a 12 month period.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
<u>Adjust Partial Denture - maxillary</u>	<u>D5421</u>	<u>\$54.4155.12</u>	<u>\$44.4145.12</u>	<u>\$10.00</u>		<u>Adjust complete maxillary denture. Frequency: two of D5421 per 12 months per client. Cannot be charged on a denture provided in last six months. Cannot be charged in addition to a rebase or reline in a 12 month period.</u>
<u>Adjust Partial Denture - mandibular</u>	<u>D5422</u>	<u>\$54.4155.12</u>	<u>\$44.4145.12</u>	<u>\$10.00</u>		<u>Adjust complete maxillary denture. Frequency: two of D5422 per 12 months per client. Cannot be charged on a denture provided in last six months. Cannot be charged in addition to a rebase or reline in a 12 month period.</u>
Repair broken complete denture base, mandibular	D5511	<u>\$131.84133.79</u>	<u>\$121.84123.79</u>	\$10.00		Repair broken complete mandibular denture base. Frequency: Two of D5511 per 12 months per client patient.
Repair broken complete denture base, maxillary	D5512	<u>\$131.84133.79</u>	<u>\$121.84123.79</u>	\$10.00		Repair broken complete maxillary denture base. Frequency: Two of D5512 per 12 months per client patient.
Replace missing or broken teeth - complete denture - (each per tooth)	D5520	<u>\$98.85100.27</u>	<u>\$88.8590.27</u>	\$10.00	<u>Teeth 1 - 32</u>	Replacement/repair of missing or broken teeth. Teeth 1 – 32 and must report tooth number.
Repair resin partial denture base, mandibular	D5611	<u>\$99.55100.98</u>	<u>\$89.5590.98</u>	\$10.00		Repair resin partial mandibular denture base. Frequency: Two of D5611 per 12 months per client patient.
Repair resin partial denture base, maxillary	D5612	<u>\$99.55100.98</u>	<u>\$89.5590.98</u>	\$10.00		Repair resin partial maxillary denture base. Frequency: Two of D5612 per 12 months per client patient.
Repair cast partial framework, mandibular	D5621	<u>\$129.27131.18</u>	<u>\$119.27121.18</u>	\$10.00		Repair cast partial mandibular framework. Frequency: Two of D5621 per 12 months per client patient.
Repair cast partial framework, maxillary	D5622	<u>\$129.27131.18</u>	<u>\$119.27121.18</u>	\$10.00		Repair cast partial maxillary framework. Frequency: Two of D5622 per 12 months per client patient.
Repair or replace broken retentive/clasping materials – per tooth	D5630	<u>\$139.66141.73</u>	<u>\$129.66131.73</u>	\$10.00	<u>Teeth 1 - 32</u>	Repair of broken clasp on partial denture base – per tooth. Teeth 1 – 32, report tooth number(s). Frequency: <u>One of D5630 per 12 months per patient per tooth.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Replace <u>missing or</u> broken teeth-per tooth	D5640	\$100.04 <u>101.48</u>	\$90.04 <u>91.48</u>	\$10.00	<u>Teeth 1 - 32</u>	Repair/replacement of missing tooth. Teeth 1 – 32, report tooth number(s). <u>Frequency: One of D5640 per 12 months per patient per tooth.</u>
Add tooth to existing partial denture – <u>per tooth</u>	D5650	\$109.00	\$99.00	\$10.00	<u>Teeth 1 - 32</u>	Adding tooth to partial denture base. <u>Frequency: One of D5650 per 12 months per patient per tooth.</u> 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 – <u>per tooth</u>	D5660	\$145.08 <u>147.24</u>	\$135.08 <u>137.24</u>	\$10.00	<u>Teeth 1 - 32</u>	Adding clasp to partial denture base – per tooth. <u>Frequency: One of D5660 per 12 months per patient per tooth.</u> 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: <u>One</u> time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase complete mandibular denture	D5711	\$322.00	\$297.00	\$25.00		Frequency: <u>One</u> 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: <u>One</u> 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: <u>One</u> 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 Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Reline complete maxillary denture (chairside/ direct)	D5730	\$190.08 192.96	\$180.08 182.96	\$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/ direct)	D5731	\$190.08 192.96	\$180.08 182.96	\$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/ direct)	D5740	\$187.69 190.53	\$177.69 180.53	\$10.00		Frequency: eOne time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (chairside/ direct)	D5741	\$189.49 192.36	\$179.49 182.36	\$10.00		Frequency: eOne 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/ indirect)	D5750	\$253.13 256.78	\$228.13 231.78	\$25.00		Frequency: eOne 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/ indirect)	D5751	\$254.31 257.98	\$229.31 232.98	\$25.00		Frequency: eOne 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/ indirect)	D5760	\$251.33 254.95	\$226.33 229.95	\$25.00		Frequency: eOne 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/ indirect)	D5761	\$251.33 254.95	\$226.33 229.95	\$25.00		Frequency: eOne 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 Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	\$119.07 <u>120.82</u>	\$109.07 <u>110.82</u>	\$10.00	<u>Teeth 1 - 32</u>	Includes removal of tooth structure, minor smoothing of socket bone, and closure as necessary. Frequency: One of D7140 per lifetime per client <u>patient</u> per tooth. Teeth 1 – 32.
Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	\$184.54 <u>187.33</u>	\$174.54 <u>177.33</u>	\$10.00	<u>Teeth 1 - 32</u>	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 <u>patient</u> per tooth. Teeth 1 - 32
Removal of impacted tooth-soft tissue	D7220	\$220.66 <u>223.87</u>	\$200.66 <u>203.87</u>	\$20.00	<u>Teeth 1 - 32</u>	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32. Frequency: One of D7220 per 4 lifetime per client <u>patient</u> per tooth.
Removal of impacted tooth-partially bony	D7230	\$272.40 <u>276.44</u>	\$252.40 <u>256.44</u>	\$20.00	<u>Teeth 1 - 32</u>	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7230 per 4 lifetime per patient per tooth
Removal of impacted tooth-completely bony	D7240	\$316.18 <u>320.92</u>	\$296.18 <u>300.92</u>	\$20.00	<u>Teeth 1 - 32</u>	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7240 per 4 lifetime per patient per tooth.
Removal of impacted tooth-completely bony, with unusual surgical complications	D7241	\$415.64 <u>442.97</u>	\$395.64 <u>401.97</u>	\$20.00	<u>Teeth 1 - 32</u>	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 Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Removal of residual tooth roots (cutting procedure)	D7250	\$194.64 <u>197.59</u>	\$184.64 <u>187.59</u>	\$10.00	<u>Teeth 1 - 32</u>	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 <u>of</u> D7250 per lifetime per patient per tooth. <u>Will not be paid to the dentists or group that removed the tooth.</u>
Primary closure of a sinus perforation	D7261	\$485.35 <u>492.96</u>	\$475.35 <u>482.96</u>	\$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.
Incisional biopsy of oral tissue - hard (bone, tooth)	D7285	\$196.67 <u>199.66</u>	\$186.67 <u>189.66</u>	\$10.00		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.
Incisional biopsy of oral tissue-soft	D7286	\$391.00	\$381.00	\$10.00		For partial removal of an architecturally intact specimen only. D7286 <u>This procedure</u> is not used at the same time as codes for apicoectomy/periradicular curettage. <u>This procedure</u> and does not entail an excision. Treatment notes must include documentation and proof that biopsy was sent for evaluation. <u>Only covered if there is a suspicious lesion.</u>

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	\$150.00 91	\$140.00 91	\$10.00	Per Quadrant LL, LR, UL, UR	D7310 The alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7310 or D7311 per lifetime per patient per quadrant. Reported per quadrant. Minimum of 4 extractions in the affected quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	\$148.69 150.91	\$138.69 140.91	\$10.00	Per Quadrant LL, LR, UL, UR	D7311 The alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7311 or D7310 per lifetime per patient per quadrant. Reported per quadrant. Maximum of 3 extractions in the affected quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	\$214.11 217.38	\$204.11 207.38	\$10.00	Per Quadrant LL, LR, UL, UR	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.
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	\$214.11 217.38	\$204.11 207.38	\$10.00	Per Quadrant LL, LR, UL, UR	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.
Excision of benign Lesion up to 1.25 cm	D7410	\$200.90 197.46203.95	\$190.90 187.46193.95	\$10.00		Must have a pathology report in file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Removal of benign nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm	D7460	\$253.4748 <u>70257.37</u>	\$243.473 <u>8.70247.37</u>	\$10.00		Must have a pathology report in file.
Removal of lateral exostosis (maxilla or mandible)	D7471	\$310.1731 <u>4.97</u>	\$300.173 <u>04.97</u>	\$10.00	<u>Per Arch LA, UA</u>	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	\$364.7937 <u>0.47</u>	\$354.793 <u>60.47</u>	\$10.00	<u>Per Quadrant LL, LR, UL, UR</u>	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	\$355.7936 <u>1.32</u>	\$345.793 <u>51.32</u>	\$10.00	<u>Per Quadrant LL, LR, UL, UR</u>	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.
Incision & drainage of abscess - intraoral soft tissue	D7510	\$196.66	\$186.66	\$10.00	<u>Teeth 1 - 32</u>	Incision through mucosa, including periodontal origins. One of D7510 per lifetime per client/patient per tooth. Report per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	<u>Teeth or</u> <u>Quadrant</u> <u>Covered</u>	PROGRAM GUIDELINES
Palliative treatment of dental pain – per visit	D9110	\$82.04 <u>95</u>	\$57.04 <u>95</u>	\$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. Treatment that relieves pain but is not curative; services provided do not have distinct procedure codes. Not allowed with any other services other than radiographs. Cannot be billed when the only other service is writing a prescription.
Evaluation for moderate sedation, deep or general anesthesia	D9219	\$43.83 <u>44.53</u>	\$43.83 <u>44.53</u>	\$0.00		One of D9219 or D9310 per 12 month(s) per grantee per patient.
<u>Deep sedation/general anesthesia - first 15 minutes</u>	<u>D9222</u>	<u>\$126.60</u>	<u>\$116.60</u>	<u>\$10.00</u>		<u>One of D9222 per 1 day per patient.</u>
Deep sedation/general anesthesia-each subsequent 15 minute increment	D9223	\$110.09 <u>111.69</u>	\$100.09 <u>101.69</u>	\$10.00		Nine of D9223 per 1 day per patient. Not allowed with D9243

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Patient Co-Pay	Teeth or Quadrant Covered	PROGRAM GUIDELINES
Intravenous moderate (conscious) sedation/analgesia-first 15 minutes	D9239	\$124.76 126.60	\$144.76 16.60	\$10.00		Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration. One of D9239 per 1 day per patient.
Intravenous moderate (conscious) sedation/analgesia-each subsequent 15 minute increment	D9243	\$110.09 111.69	\$100.09 101.69	\$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 – Mesial, Distal, Occlusal, Lingual, or Buccal	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.

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

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Outpatient Hospital Payment Rule Regarding 340B Drug Pricing, Section 8.300.6.A.1.j.
Rule Number: MSB 25-05-06-A
Division / Contact / Phone: Fee for Service Rates / Andrew Abalos / 2130

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 25-05-06-A, Revision to the Medical Assistance Act Outpatient Hospital Payment Rule Regarding 340B Drug Pricing, Section 8.300.6.A.1.j.
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):
Sections(s) 8.300.6.A.1.J, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
If yes, state effective date: 07/01/2025
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.300.6.A.1.j through the end of 8.600.6.A.1.j. This rule is effective July 1, 2025.

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Title of Rule: Revision to the Medical Assistance Act Outpatient Hospital Payment Rule
Regarding 340B Drug Pricing, Section 8.300.6.A.1.j.

Rule Number: MSB 25-05-06-A

Division / Contact / Phone: Fee for Service Rates / Andrew Abalos / 2130

STATEMENT OF BASIS AND PURPOSE

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

Senate Bill, or the Long Bill, 21-205 was signed by Governor Polis on May 21, 2021, which included rate adjustments to be effective July 1, 2021 and ongoing. The Long Bill included a reduction to 340B drug pricing in the outpatient hospital setting which was not implemented. However, the Department is mandated to implement such rate changes, and as such is seeking to do so effective July 1, 2025. This rule change is necessary to bring the Department's payments into budgetary authority.

2. An emergency rule-making is imperatively necessary

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

Explain:

The Department must comply with its budgetary authority. The Department perpetuates a source of overexpenditure by continuing to allow provider payments at a rate unauthorized by the Joint Budget Committee.

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);
Senate Bill 21-205

Initial Review
Proposed Effective Date

07/01/25

Final Adoption
Emergency Adoption

06/13/25
DOCUMENT #

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Title of Rule: Revision to the Medical Assistance Act Outpatient Hospital Payment Rule Regarding 340B Drug Pricing, Section 8.300.6.A.1.j.

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REGULATORY ANALYSIS

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

Hospitals which participate in the 340B Drug Pricing program that are billing the Department for drugs provided to Health First Colorado members in the outpatient hospital setting will be affected by this rule, as their reimbursements for these drugs will be reduced.

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 rate reduction proposed in the Long Bill was anticipated to reduce 340B outpatient hospital drug payments to hospitals by \$6.5 million, which represents more than \$2.1 million in savings to general and cash funds. Using a more recent set of claims data, e.g. State Fiscal Year 2024, this rule change is anticipated to reduce hospital provider payments by approximately \$10 million in outpatient hospital claims annually.

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 no probable costs to the Department or to any other agency for the implementation and enforcement of the proposed rule. The proposed rule is anticipated to reduce Department expenditures.

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

The probable benefit of the proposed rule is that it will allow the Department to comply with its budgetary authority. The costs of inaction include the continuation of the Department spending outside of its budgetary authority, in addition to the dollar costs associated with this increased expenditure.

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

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

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

There are no alternative methods for achieving the purpose of the proposed rule.

8.300 HOSPITAL SERVICES

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.

Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

Effective July 1, 2013, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.8 percent (29.8%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8 percent (29.8%) or billed charges less 29.8 percent (29.8%).

Effective July 1, 2014, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28.4 percent (28.4%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28.4 percent (28.4%) or billed charges less 28.4 percent (28.4%).

Effective July 1, 2015, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28 percent (28%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

Effective October 31, 2016, DRG Hospitals will be reimbursed for Outpatient Hospital Services based on a system of Enhanced Ambulatory Patient Grouping and a Hospital-specific Medicaid Outpatient base rate. The reimbursement for Outpatient Hospital Services shall be referred to as the EAPG Payment.

- a. The EAPG Payment will be equal to the EAPG Weight multiplied by the Hospital-specific Medicaid Outpatient base rate for that hospital as calculated in 10 CCR 2505-10, Section 8.300.6.A.1.k. If the EAPG Weight is modified due to any action impacting payment as described in sections 8.300.6.A.1.d-j, the modified EAPG Weight will be referred to as the EAPG Adjusted Weight. EAPG Payment will then be equal to the EAPG Adjusted Weight multiplied by the Hospital-specific Medicaid Outpatient base rate. If the billed amount is less than the EAPG Payment, reimbursement will be the billed amount.
- b. The EAPG Payment is calculated for each detail on the claim. Claim details with the same dates of service are grouped into a visit. Claims containing details describing charges for emergency room, treatment room services or patients placed under observation will have all its details grouped into a single visit.
- c. Each detail on a claim is assigned an EAPG. EAPGs can have the following types:
 - (1) Per Diem
 - (2) Significant Procedure. Subtypes of Significant Procedures Are:
 - (a) General Significant Procedures
 - (b) Physical Therapy and Rehabilitation
 - (c) Behavioral Health and Counseling

- (d) Dental Procedure
- (e) Radiologic Procedure
- (f) Diagnostic or Therapeutic Significant Procedure
- (3) Medical Visit
- (4) Ancillary
- (5) Incidental
- (6) Drug
- (7) Durable Medical Equipment
- (8) Unassigned

- d. A detail will be subject to EAPG Consolidation when it is assigned the same Significant Procedure EAPG as a detail not already subjected to EAPG Consolidation for that visit. EAPG Consolidation will also occur for details assigned EAPGs considered to be clinically similar to another EAPG during the visit. Details subject to EAPG Consolidation will have an EAPG Payment calculated using an EAPG Weight of 0.
- e. A detail will be subject to EAPG Packaging when its assigned EAPG is considered an ancillary service to a Significant Procedure EAPG or Medical Visit EAPG present on the claim for that visit. Details describing additional undifferentiated medical visits and services will be exempt from EAPG Packaging. A detail is also subject to EAPG Packaging when it is assigned a Medical Visit EAPG while a Significant Procedure EAPG is present on the claim for that visit. Details assigned Significant Procedure EAPGs that are not General Significant Procedures do not cause details with Medical Visit EAPGs to be subject to EAPG Packaging. Details subject to EAPG Packaging will be calculated using an EAPG Weight of 0.
- f. A detail will qualify for Multiple Significant Procedure Discounting when a Significant Procedure of the same subtype is present on the claim for that visit. Details qualifying for Multiple Significant Procedure Discounting are ordered by their EAPG Weight, by visit. Per visit, the qualifying detail with the greatest EAPG Weight will have its EAPG Payment calculated at 100 percent (100%) of its EAPG Weight. The qualifying detail for that visit with the next greatest EAPG Weight will have its EAPG Payment calculated at 50 percent (50%) of its EAPG Weight. All other qualifying details for that visit will have its EAPG Payment calculated at 25 percent (25%) of its EAPG Weight.
- g. Details assigned the same Ancillary EAPG on the same visit will qualify for Repeat Ancillary Discounting. EAPG Payment for the first occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 100 percent (100%) of its EAPG Weight. EAPG Payment for the second occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 50 percent (50%) of its EAPG Weight. EAPG Payment for all other details qualifying for Repeat Ancillary Discounting for that visit and EAPG will be calculated using 25 percent (25%) of their EAPG Weights.

- h. Details describing terminated procedures will be subject to Terminated Procedure Discounting. EAPG Payment for a detail subject to Terminated Procedure Discounting is calculated using 50 percent (50%) of the EAPG Weight. Terminated procedures are not subject to other types of discounting.
- i. Details describing bilateral services will have EAPG Payment calculated using 150 percent (150%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.
- j. Details describing 340B Drugs will have an EAPG Payment calculated using ~~80~~ 65 percent (~~80~~65%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.
- k. The Hospital-specific Medicaid Outpatient base rate for January 1, 2022 for each hospital is calculated using the following method.
 - (1) Assign each hospital to one of the following groups based on hospital type and location:
 - (a) Pediatric Hospitals
 - (b) Critical Access Hospitals
 - (c) Non-Critical Access, System Hospitals
 - (d) Independent Hospitals
 - (e) Rehabilitation, Long-term Acute Care, and Brain/Spine Injury Hospitals
 - (2) Rehabilitation, Long-term Acute Care, and Brain/Spine Injury Hospitals are assigned their same hospital-specific base rate as effective immediately prior to January 1, 2022.
 - (3) Process Medicaid outpatient hospital claims from calendar year 2019 through the methodology described in 8.300.6.A.1.a-j using 3M's EAPG Relative Weights, scaled for budget neutrality purposes, and version 3.16 of the Enhanced Ambulatory Patient Grouping methodology. Hospital payment rates from version 3.10 of the methodology are then compared to the version 3.16 payment rates using the hospital-specific base rates immediately prior to January 1, 2022.
 - (4) For Critical Access Hospitals, a weighted average base rate by outpatient hospital visit is calculated EAPG payments for Critical Access Hospitals under version 3.10 and 3.16 are calculated using this weighted average base rate, then an inflation factor is applied to determine a revenue neutral rate for the Critical Access Hospital group. This inflation factor is then applied to all Critical Access Hospital rates effective immediately prior to January 1, 2022. For all other hospitals, with the exception of Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, a revenue neutral rate is calculated which aligns payment under version 3.16 of EAPGs to payments calculated under version 3.10.

- (5) For Critical Access Hospitals, the average and standard deviation of their rates with the inflation factor applied is calculated. All Critical Access Hospitals with a rate falling below 1 standard deviation of the average is given a rate at 1 standard deviation below the average. For Critical Access Hospitals with a rate above 2 standard deviations of the average is given a rate at 2 standard deviations above the average. For each other hospital group, except Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, the average and standard deviation of their rates are calculated. For hospitals that have a rate below 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations below the group's average rate. For hospitals that have a rate above 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations above the group's average rate.
- (6) For new, in-state hospitals, such hospitals will be assigned to a Pediatric, Long Term Acute Care, or Rehabilitation peer group depending on hospital type. If a provider does not meet the criteria for any of the above peer groups, it will be assigned to a Rural or Urban peer group based on location. The hospital will receive a base rate of the average peer-group rate as calculated from Colorado hospitals base rate statistics.
- (7) For all hospitals, the Medicaid Outpatient base rate, as determined in 8.300.6.A.k.(1)-(6), shall be adjusted by an equal percentage, when required due to changes in the available funds appropriated by the General Assembly. The application of this change to the Medicaid Outpatient base rate shall be determined by the Department.

- I. Effective June 1, 2020, by the modification of the EAPG Weights, the allowed reimbursement of outpatient hospital drugs shall be increased by 42.93% for drugs provided at Critical Access Hospitals and Medicare Dependent Hospitals, and decreased by 3.47% for drugs provided at non-independent urban hospitals.

2. Payments to Out-of-Network DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

Out-of-Network DRG Hospitals will be reimbursed for Outpatient Hospital Services based on the system of Enhanced Ambulatory Patient Grouping described in Section 8.300.6.A.1. Such hospitals will be assigned to a Pediatric, Long Term Acute Care, or Rehabilitation peer group depending on hospital type. If a provider does not meet the criteria for any of the above peer groups, it will be assigned to a Rural or Urban peer group based on location. The hospital will receive a base rate of 90% of the average peer group rate as calculated from Colorado hospitals base rate statistics. Out-of-Network DRG Hospitals will periodically have their Medicaid Outpatient base rates adjusted as determined in Section 8.300.6.A.k.7.

3. Payments for Outpatient Hospital Specialty Drugs

Effective August 11, 2018, for services meeting the criteria of an Outpatient Hospital Specialty Drug that would have otherwise been compensated through the EAPG

methodology, a hospital must submit a request for authorization to the Department prior to administration of the drug. If the request is approved, then the payment will be negotiated between the Department and the hospital on a case-by-case basis.

4. **Payments for Select Outpatient Hospital Opioid Antagonist Drugs**

Pursuant to C.R.S. § 25.5-5-509, effective July 8, 2022, payments for select Outpatient Hospital Opioid Antagonist Drugs that would have otherwise been compensated through the EAPG methodology will be reimbursed at either the lower of the billed charges or the fee schedule rate.