DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE – SECTION 8.900 CICP, OAP, Primary Care Fund, Dental Health Care

10 CCR 2505-10 8.900

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

8.900 COLORADO INDIGENT CARE PROGRAM (CICP)

PROGRAM OVERVIEW AND LEGAL BASIS

The Colorado Indigent Care Program (CICP) is a program that distributes federal and State funds to partially compensate Qualified Health Care Providers for uncompensated costs associated with services rendered to uninsured or underinsured patients. Qualified Health Care Providers who receive this funding render discounted health care services to Colorado residents, migrant workers and lawfully present immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to Qualified Health Care Providers who serve eligible persons. The CICP issues procedures to ensure the funding is used to serve the uninsured and underinsured population in a uniform method. Any significant departure from these procedures will result in termination of the approval of, and the funding to, a health care provider. The CICP is authorized by state law at Title 25.5, Article 3, Part 1.

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in section 10-16-102(34), C.R.S. Eligible persons receiving discounted health care services from Qualified Health Care Providers are subject to the limitations and requirements imposed by Title 25.5, Article 3, Part 1, C.R.S.

8.901 DEFINITIONS

A. Applicant means an individual who has applied at a Qualified Health Care Provider to receive discounted health care services.

B. Children's Basic Health Plan or the Child Health Plan Plus (CHP+) means the Children's Basic Health Plan as defined in Title 25.5, Article 8, C.R.S.

C. Client means an individual whose application to receive discounted health care services has been approved by a Qualified Health Care Provider.

D. Clinic Provider means any Qualified Health Care Provider that is a community health clinic licensed or certified by the Department of Public Health and Environment pursuant to C.R.S §25-1.5-103, a federally qualified health center as defined in 42 U.S.C. sec. 1395x (aa)(4), or a rural health clinic, as defined in 42 U.S.C. sec. 1395x (aa)(2).

E. Colorado Indigent Care Program or CICP or Program means the Colorado Indigent Care Program as authorized by state law at Title 25.5, Article 3, Part 1, C.R.S.

F. Denver Metropolitan Area means the Denver-Aurora-Lakewood, CO metropolitan area as defined by the Bureau of Labor Statistics.

G. Department means the Department of Health Care Policy and Financing established pursuant to section 25.5-1-104, C.R.S.

H. Doubled-up means a person who has no permanent housing of their own and who is temporarily living with a person who has no legal obligation to financially support them.

I. Emergency Care means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

J. General Provider means a general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., a federally qualified health center, as defined in 42 U.S.C. sec. 1395x(aa)(4), a rural health clinic, as defined in 42 U.S.C. sec. 1395x(aa)(2), a health maintenance organization issued a certificate authority pursuant to Section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to Section 25.5-3-108(5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the Program, General Provider includes associated physicians.

   42 U.S.C. sec. 1395x(aa)(2) (2021)is incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203.

K. Homeless means a person who lacks a fixed, regular, and adequate night-time residence, or is in a doubled-up situation, or is in imminent danger of losing their primary night-time residence, and who lacks resources or support networks to remain in housing, or has a primary night-time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

L. Hospital Discounted Care means Health Care Billing for Indigent Patients as defined in Title 25.5, Article 3, Part 5, C.R.S.

M. Hospital Provider means any Qualified Health Care Provider that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to section 25-1.5-103, C.R.S. and which operates inpatient facilities.

N. Liquid Resources means resources that can be readily converted to cash, including but not limited to checking and savings accounts, health savings accounts, prepaid bank cards, certificates of deposit less the penalty for early withdrawal.

O. Medicaid means the Colorado medical assistance program as defined in Title 25.5, Article 4, C.R.S.

P. Qualified Health Care Provider means any General Provider who is approved by the Department to provide, and receive funding for, discounted health care services under the CICP.

Q. Spend Down means when an Applicant uses his or her available Liquid Resources to pay off part or all of a medical bill to lower his or her financial determination to a level that will allow him or her to qualify for the Program.

R. Transitional housing means housing designed to provide homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing.

S. Uniform Application means the application for discounted care created pursuant to Section 8.922.

T. Urgent Care means treatment needed because of an injury or serious illness that requires treatment within 48 hours.

8.902 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Requirements for Qualified Health Care Providers

1. Agreements will be made annually between the Department and Qualified Health Care Providers through an application process.

2. Agreements may be executed with Hospital Providers throughout Colorado that meet the following requirements:

a. Licensed or certified as a general hospital or birth center by the Department of Public Health and Environment.

b. Hospital Providers shall provide Emergency Care to all Clients throughout the Program year at discounted rates.

c. Hospital Providers shall have at least two obstetricians with staff privileges at the Hospital Provider who agree to provide obstetric services to individuals under Medicaid. In the case where a Hospital Provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term “obstetrician” includes any physician with staff privileges at the Hospital Provider to perform non-emergency obstetric procedures.

This requirement does not apply to a Hospital Provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

d. Using the information submitted by an Applicant and the Uniform Application developed and distributed by the Department, the Qualified Health Care Provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination shall be made within three business days of receipt of the missing documents. Hospital Providers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age 18 and older;

II. Household size, where all non-spouse or civil union partner, non-student adults ages 18 to 64 included on the application must have financial support demonstrated or attested to

i. An applicant must include their spouse or civil union partner in their household for purposes of the application.

ii. Any additional person living at the same address as the applicant may also be included in the household.

iii. An applicant may include household members who live in other states or countries if the applicant attests that they provide at least 50% of the household member's support; and

III. Liquid Resources. Including Liquid Resources in the financial eligibility determination is optional for Hospital Providers. If a Hospital Provider chooses to include Liquid Resources in the financial eligibility determination, at least $2,500 must be excluded for each family member counted in household size, and the Hospital Provider must include a Spend Down opportunity. Effective June 1, Liquid Resources may no longer be counted for applicants.

e. Hospital Providers shall use the Sliding Fee Scale developed by the Department or submit for Department approval with their annual application a Sliding Fee Scale that shows copayments for different service categories divided into at least three income tiers covering 0 to 250% of the federal poverty level. Copayments shall be expressed in dollar amounts and shall not exceed the copayments in the Standard Client Copayment Table found in Appendix A. Hospital Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.

f. Hospital Providers shall submit Program utilization and charge data in a format and timeline determined by the Department.

3. Agreements may be executed with Clinic Providers throughout Colorado that meet the following minimum criteria:

a. Licensed or certified as a community health clinic by the Department of Public Health and Environment or certified by the U.S. Department of Health and Human Services as a federally qualified health center or rural health clinic.

b. Using the information submitted by an Applicant, the provider shall use the Uniform Application developed and distributed by the Department to determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Clinic Providers may develop their own application and submit it to the Department for approval. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination shall be made within three business days of receipt of the missing documents. Clinic Providers who are federally qualified health centers shall determine Client financial eligibility as required under federal regulations and guidelines. Clinic Providers who are not federally qualified health centers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age 18 and older, and

II. Household size.

c. Clinic Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories. Copayments for Clients between 0 and 100% of the federal poverty level shall be nominal or $0. Sliding Fee Scales shall have at least three tiers between 101 and 250% of the federal poverty level.

I. Sliding fee scales used by federally qualified health centers approved by the federal government meet all requirements of the Program.

II. Copayments for Clients between 101 and 250% of the federal poverty level may not be less than the copayments for Clients between 0 and 100% of the federal poverty level.

III. The same sliding fee scale shall be used for all Clients eligible for the Program.

IV. Sliding fee scales shall be reviewed by the Qualified Health Care Provider on a regular basis to ensure there are no barriers to care.

d. Clinic Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.

e. Clinic Providers shall submit Program data and quality metrics with their annual application. Specific quality metrics are listed in Section 8.905.B. The data and quality metrics shall be submitted in a format determined by the Department and provided as part of the annual application.

4. Determination of Lawful Presence

a. Effective July 1, 2022, Applicants are no longer required to provide proof of lawful presence in order to be eligible for the CICP.

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

c. Qualified Health Care Providers shall accept copies of an Applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter.

d. Qualified Health Care Providers shall retain photocopies of the Applicant's affidavit and lawful presence documentation.

e. Qualified Health Care Providers shall assist applicants who have a disability, are homeless, or who lack proficiency in English with obtaining documentation to establish citizenship or lawful presence.

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

II. Examples of additional assistance that shall be provided to Applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the Applicant.

III. The Qualified Health Care Provider shall not be required to pay for the cost of obtaining required documentation.

IV. The Qualified Health Care Provider shall document its efforts of providing additional assistance to the Applicant and retain such documentation.

5. Qualified Health Care Providers shall provide the Applicant and/or representative a written notice in the Applicant's preferred language of the provider's determination as to the Applicant's eligibility to receive discounted services under the Program. If eligibility to receive discounted health care services is granted by the Qualified Health Care Provider, the notice shall include the dates of eligibility and the Applicant's copay responsibilities. If eligibility to receive discounted health care services is denied, the notice shall include a brief, plain language explanation of the reason(s) for the denial. Every notice of the Qualified Health Care Provider's decision, whether an approval or a denial, shall include an explanation of the Applicant's appeal rights found at Section 8.902.B in these regulations.

6. Qualified Health Care Providers shall screen all Applicants for eligibility for Medicaid and the Children's Basic Health Plan and refer Applicants to those programs if they appear eligible. The Qualified Health Care Provider shall refer Applicants to Colorado's health insurance marketplace for information about private health insurance.

7. Qualified Health Care Providers shall not discriminate against Applicants or Clients based on race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.

B. Client Appeals

1. If an Applicant or Client feels that a financial determination or denial is in error, he or she shall only challenge the financial determination or denial by filing an appeal with the Qualified Health Care Provider who determined eligibility to receive discounted health care services under the CICP pursuant to this Section 8.902. There is no appeal process available through the Office of Administrative Courts.

2. Instructions for Filing an Appeal

   The Qualified Health Care Provider shall inform the Applicant or Client that he or she has the right to appeal the financial determination or denial if he or she is not satisfied with the Qualified Health Care Provider's decision.

   An Applicant or Client who wishes to appeal a denial must:

   a. Submit a letter requesting appeal within 30 calendar days of the date of the denial notice. Appeals submitted after the deadline may be denied for being submitted untimely;

   b. Enclose any supporting documentation;

   If no denial notice is received earlier, an appeal letter may be submitted within 45 calendar days of the date the application was completed. The deadline for an appeal letter may be extended for good cause.

3. Appeals

   a. An Applicant or Client may file an appeal if he or she wishes to challenge the accuracy of his or her initial financial determination.

   b. Each Qualified Health Care Provider must designate a manager to review appeals and supporting documentation.

   c. If the initial financial determination is found to be inaccurate,

      I. the financial determination will be corrected, with eligibility effective retroactive to the initial date of application, and

      II. services provided during the applicable backdating period must be discounted.

   d. A decision shall be issued to the Applicant or Client and the Department in writing within 15 calendar days following receipt of the appeal request.

4. Provider Management Exception

   a. An Applicant or Client may request a provider management exception simultaneously with an appeal, or within 15 calendar days of the date of the Qualified Health Care Provider’s decision regarding an appeal.

   b. A provider management exception may be granted at the Qualified Health Care Provider’s discretion if the Applicant or Client can demonstrate that there are circumstances that should be taken into consideration when establishing the household financial status.

   c. Each Qualified Health Care Provider must designate a manager to review provider management exceptions and supporting documents.

      I. The facility shall notify the Client in writing of the Qualified Health Care Provider’s findings within 15 calendar days of receipt of the Client’s written request.

II. The Qualified Health Care Provider must note provider management exceptions on the application.

d. A financial determination from a provider management exception is effective as of the initial date of application.

e. Qualified Health Care Providers are not required to honor provider management exceptions granted by other Qualified Health Care Providers.

C. Financial Eligibility

General Rule: An Applicant shall be financially eligible for discounted health care services under the CICP if their household income is no more than 250% of the current Federal Poverty Guidelines(FPG)for a household of that size.

1. Qualified Health Care Providers determine eligibility for the CICP and shall maintain auditable files of applications for discounted health care services under the CICP until June 30 of the seventh state fiscal year following the eligibility determination.

2. The determination of financial eligibility process looks at the financial circumstances of a household as of the date that an application is started. In the event that an applicant is applying to cover a past individual visit or admission, or a string of visits, admissions, or both that occurred in a short amount of time and is either not going to be applying for CICP going forward or the date(s) of service are outside of the standard 90 day backdating window, the household financial status is considered as of the date of service instead of the date of the application.

3. All Qualified Health Care Providers must accept each other's CICP financial determinations unless the Qualified Health Care Provider believes that the financial determination was determined incorrectly, the Qualified Health Care Provider's financial determination process is materially different from the process used by the issuing Qualified Health Care Provider, or that the financial determination was a result of a provider management exception.

4. CICP eligibility is retroactive for services received from a Qualified Health Care Provider up to 90 days prior to application.

5. Documentation concerning the Applicant's financial status shall be maintained by the provider until June 30 of the seventh state fiscal year following the eligibility determination.

6. Beyond the distribution of available funds made by the CICP, allowable Client copayments, and other third-party sources, a provider shall not seek payment from a Client for the provider's CICP discounted health care services to the Client.

7. Emergency Application for Providers

a. In emergency circumstances, an Applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the Qualified Health Care Provider shall follow these steps in processing the application:

I. Use the regular application to receive discounted health care services under the CICP but indicate emergency application on the application.

II. Ask the Applicant to give spoken answers to all questions and determine a federal poverty level based on the spoken information provided. If the Applicant appears eligible for Medicaid or CHP+, the Applicant will need to apply for the applicable program prior to being placed on CICP.

III. .Ask the Applicant to sign the application indicating their understanding of their federal poverty level and eligibility determination made using their spoken information.

b. An emergency application is good for only one episode of service in an emergency room and any subsequent service related to the emergency room episode. If the Client receives any care other than the emergency room visit, the Hospital Provider must request the Client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the Client does not support the earlier, spoken information, the Hospital Provider must obtain a new application from the Client. If the Client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the emergency application.

c. In emergency circumstances, an Applicant is not required to provide identification or execute an affidavit as specified at Section 8.904.D.

D. Audit Requirements

The Department will conduct audits of Qualified Health Care Providers. Qualified Health Care Providers shall comply with requests for data and other information from the Department. Qualified Health Care Providers shall complete corrective actions when required by the Department. The Department's intention is to audit one-third of the participating Qualified Health Care Providers each year. After any Qualified Health Care Provider discontinues participation in the program, the provider must maintain compliance with audit requirements for the records created during the period during which the Qualified Health Care Provider was participating.

E. HIPAA

The CICP does not meet the definition of a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 at 45 C.F.R. sec. 160.103. The CICP is not a part of the Colorado Medical Assistance Program, nor of Health First Colorado, Colorado's Medicaid program. CICP's principal activity is the making of grants to providers who serve eligible persons who are uninsured or underinsured. The state personnel administering the CICP will provide oversight in the form of procedures and conditions to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a Qualified Health Care Provider or Client.

8.903 DISCOUNTED HEALTH CARE SERVICES

A. Funding provided under the CICP shall be used to provide Clients with discounted health care services determined to be medically necessary by the Qualified Health Care Provider.

B. All health care services normally provided at the Qualified Health Care Provider should be available at a discount to Clients. If health care services normally provided at the Qualified Health Care Provider are not available to Clients at a discount, Clients must be informed that the services can be offered without a discount prior to the rendering of such services. Service availability is to be applied uniformly for all Clients.

C. Qualified Health Care Providers receiving funding under the CICP shall prioritize the use of funding such that discounted health care services are available in the following order:

1. Emergency Care;

2. Urgent Care; and

3. Any other medical care.

D. Additional discounted health care services may include:

1. Emergency mental health services if the Qualified Health Care Provider renders these services to a Client at the same time that the Client receives other medically necessary services.

2. Qualified Health Care Providers may provide discounted pharmaceutical services. The Qualified Health Care Provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the Qualified Health Care Provider. Qualified Health Care Providers shall exclude prescription drugs included in the definition of Medicare Part-D from eligible Clients who are also eligible for Medicare.

3. Qualified Health Care Providers may provide packages of services to patients with modified copayment requirements.

a. Packages of services benefit Clients who need to utilize services more often than average Clients. Things that would be beneficial to the client include but are not limited to charging a lower copay, charging the copay on an alternative schedule (i.e. once a week, or ever other time), or setting a cap on the amount or number of copayments made towards the packaged services. Examples of packages may include but are not limited to oncology treatments, physical therapy, and dialysis.

b. Qualified Health Care Providers may provide a prenatal benefit with a predetermined copayment designed to encourage access to prenatal care for uninsured or underinsured women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The Qualified Health Care Provider is responsible for providing a description of the services included in the prenatal benefit to the Client prior to services rendered. Services and copayments may vary among sites.

E. Excluded Discounted Health Care Services

Funding provided under the CICP shall not be used for providing discounted health care services for the following:

1. Non-urgent dental services.

2. Nursing home care.

3. Chiropractic services.

4. Cosmetic surgery.

5. Experimental and non-United States Federal Drug Administration approved treatments.

6. Elective surgeries that are not medically necessary.

7. Court ordered procedures, such as drug testing.

8. Abortions - Except as specified in section 25.5-3-106, C.R.S.

9. Mental health services in clinic settings pursuant to section 25.5-3-110, C.R.S., Title 27, Article 66, Part 1, any provisions of Title 23, Article 22, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

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

1. Execute an affidavit regarding citizenship status;

   a. Beginning on July 1, 2022, applicants are no longer required to execute an affidavit regarding citizenship status.

2. Be lawfully present in the United States;

   a. Beginning on July 1, 2022, applicants are no longer required to be lawfully present in the United States.

3. Be a resident of Colorado;

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

5. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, or meet one of the following exceptions:

   a. individual is an unborn child;

   b. individual is homeless and unable to provide a SSN;

   c. individual is ineligible for a SSN:

   d. individual may only be issued a SSN for a valid non-work reason in accordance with 20 C.F.R. sec. 422.104;

   e. individual refuses to obtain a SSN because of well-established religious objections.

B. Applicants

1. Any adult age 18 and older may apply to receive discounted health care services on behalf of themselves and members of the Applicant’s family household.

2. If an Applicant is deceased, the personal representative of the estate or a family member may complete the application on behalf of the Applicant. The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.

3. The application to receive discounted health care services under available CICP funding shall include the names of all members of the Applicant's family household. All non-spouse or civil union partner, non-student adults ages 18-64 must have financial support demonstrated or attested to in order to be included in household size. All minors and those 65 or older do not need documentation of financial support to be counted in household size. Income from spouses or civil union partners and all non-student adults must be included in the application.

4. A minor shall not be rated separately from his or her parents or guardians unless he or she is emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Signing the Application

The Applicant or an authorized representative of the Applicant must sign the application to receive discounted health care services submitted to the Qualified Health Care Provider within 90 calendar days of the date of health care services. If an Applicant is unable to sign the application or has died, a spouse, civil union partner, relative, or guardian may sign the application. Until it is signed, the application is not complete, the Applicant cannot receive discounted health care services under the CICP, and the Applicant has no appeal rights. All information needed by the provider to process the application must be submitted before the application is signed.

D. Affidavit

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

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

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

2. For an Applicant who has executed an affidavit stating that he or she is lawfully present in the United States but is not a United States citizen, the provider shall verify lawful presence through the Federal Systematic Alien Verification for Entitlements (SAVE) Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security within three business days of receipt of the lawful presence documentation. A SAVE verification is not needed for Applicants who provide an ID issued by a REAL ID Act compliant state that bears the REAL ID Act indicator.

3. Effective July 1, 2022, Applicants are no longer required to execute an affidavit of lawful presence.

E. Establishing Lawful Presence

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

2. Submission of Documentation

   Lawful presence documentation may be accepted from the Applicant, the Applicant's spouse, civil union partner, parent, guardian, or authorized representative in person, by mail, by email, or facsimile.

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

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

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

   c. If an Applicant does not present documentation proving their lawful presence but instead presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document, file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify status.

4. Effective July 1, 2022, Applicants are no longer required to provide proof of lawful presence.

F. Residence in Colorado

An Applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.

Migrant workers and all dependent family members must meet all of the following criteria to comply with residency requirements:

1. Maintains a temporary home in Colorado for employment reasons;

2. Meet the lawful presence criteria, as defined in paragraph E of this Section; and

3. Employed in Colorado.

G. Applicants Not Eligible

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

   a. Individuals for whom lawful presence cannot be verified.

      I. Effective July 1, 2022, lawful presence is no longer a requirement for CICP, and these individuals are no longer ineligible for discounted services.

   b. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal

facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who do not have freedom of movement and association, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.

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

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

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

I. QMB benefits described at Section 8.100.6.L of these regulations;

II. SLMB benefits described at Section 8.1006.M, or

III. The QI1 benefits described at Section 8.100.6.N.

f. Individuals who are eligible for the Children's Basic Health Plan.

H. Health Insurance Information

The Applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.

I. Subsequent Insurance Payments

If a Client receives discounted health care services under the CICP, and their insurance subsequently pays for services, or if the Client is awarded a settlement, the insurance company or patient shall reimburse the Qualified Health Care Provider for discounted health care services rendered to the Client.

8.905 DEPARTMENT RESPONSIBILITIES

A. Provider Application

1. The Department shall produce and publish a provider application annually.

a. The application will be updated annually to incorporate any necessary changes and update any Program information.

b. The application will include data and quality metric submission templates.

2. The Department shall determine Qualified Health Care Providers annually through the application process.

3. An agreement will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by Section 25.5-3-108(5)(a)(I), C.R.S.

4. An agreement will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver Metropolitan Area and complex care that is not contracted for in the remaining areas of the state, as required by Section 25.5-3-108(5)(a)(II), C.R.S.

5. The Department shall produce and publish a provider directory annually.

B. Payments to Providers

1. Funding for hospitals shall be distributed in accordance with Sections 8.300 and 8.905.B.3.

2. Clinics

a. Funding for Clinic Providers is appropriated through the Colorado General Assembly under the Children's Hospital, Clinic Based Indigent Care line item. Effective July 1, 2018, funding for clinics shall be separated into two different groups, as follows:

I. 75 percent of the funding will be distributed based on Clinic Providers' write off costs relative to the total write off costs for all Clinic Providers.

II. 25 percent of the funding will be distributed based on a points system granted to Clinic Providers based on their quality metric scores multiplied by the Clinic Provider's total visits from their submitted Program data.

b. The quality metric scores will be calculated based on the following four metrics. The metrics are defined by the Health Resources & Services Administration (HRSA):

I. Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up

II. Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan

III. Diabetes: Hemoglobin A1c Poor Control

IV. Controlling High Blood Pressure

c. Write off costs will be calculated as follows:

I. Distribution of available funds for CICP care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate CICP charges.

II. Clinic Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department.

III. Clinic Providers shall deduct the full patient liability amount from total charges, which is the amount due from the Client as identified in the CICP Standard Client Copayment Table, as defined under Appendix A in these rules, or an alternative sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the

Department. The summary information submitted to the Department by the provider shall include the full CICP patient liability amount even if the Clinic Provider receives the full payment at a later date or through several smaller installments or no payment from the Client.

IV. CICP charges will be converted to CICP costs using the most recently available cost-to-charge ratio from the Clinic Provider's cost report or other financial documentation accepted by the Department.

d. The Department shall notify Clinic Providers of their expected payment no later than August 31 of each year. The notification shall include the total expected payment and a description of the methodology used to calculate the payment.

3. Pediatric Major Teaching Hospital Payment. Hospital Providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with CICP care days (days of care provided under the CICP) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:

a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.s;

b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.s per licensed bed;

c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations;

d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and

e. Participates in the CICP.

The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

C. Provider Appeals

1. Any provider who submits an application to become a Qualified Health Care Provider whose application is denied may appeal the denial to the Department.

2. The provider's first level appeal must be filed within five business days of the receipt of the denial letter. The Department's Special Financing Division Director will respond to any first level appeals within ten business days of receipt of the appeal.

3. If a provider disagrees with the Department's Special Financing Division Director's first level appeal determination, they may file a second level appeal within five business days of the receipt of the first level appeal determination. The Department's Executive Director will respond to the second level appeal within ten business days of the receipt of the second level appeal.

D. Advisory Council

The Department shall create a CICP Stakeholder Advisory Council, effective July 1, 2017. The Executive Director of the Department shall appoint 11 members to the CICP Stakeholder Advisory Council. Members shall include:

1. A member representing the Department;

2. Three consumers who are eligible for the Program or three representatives from a consumer advocate organization or a combination of each;

3. A representative from a federally qualified health center as defined at 42 U.S.C. sec. 1395x (aa)(4);

4. A representative from a rural health clinic as defined at 42 U.S.C. sec. 1395x (aa)(2), or a representative from a clinic licensed or certified as a community health clinic by the Department of Public Health and Environment, or a representative from an organization that represents clinics who are not federally qualified health centers;

5. A representative from either Denver Health or University Hospital;

6. A representative from an urban hospital;

7. A representative from a rural or critical access hospital;

8. A representative of an organization of Colorado community health centers, as defined in the federal “Public Health Service Act”, 42 U.S.C. sec. 254b;

9. A representative from an organization of Colorado hospitals.

Members shall serve without compensation or reimbursement of expenses. The Executive Director shall at least annually select a chair for the council to serve for a maximum period of twelve months. The Department shall staff the council. The council shall convene at least twice every fiscal year according to a schedule set by the chair. Members of the council shall serve three-year terms. In the event of a vacancy on the advisory council, the executive director shall appoint a successor to fill the unexpired portion of the term of such member.

The council shall

1. Advise the Department of operation and policies for the Program

2. Make recommendations to the Medical Services Board regarding rules for the Program

E. Annual Report

1. The Department shall prepare an annual report concerning the status of the Program to be submitted to the Health and Human Services committees of the Senate and House of Representatives, or any successor committees, no later than February 1 of each year.

2. The report shall at minimum include charges for each Qualified Health Care Provider, numbers of Clients served, and total payments made to each Qualified Health Care Provider.

10 CCR 2505-10 § 8.900 APPENDIX A: STANDARD CICP CLIENT COPAYMENT

A. Client Copayments - General Policies

A Client is responsible for paying a portion of his or her medical bills. The Client's portion is called the Client Copayment. Qualified Health Care Providers are responsible for charging the Client a copayment. Qualified Health Care Providers may require Clients to pay their copayment prior to receiving care (except for Emergency Care). Qualified Health Care Providers may charge copayments in accordance with the Standard Client Copayment Table or an alternate sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department.

Percent of FPL	0 - 40% and Homeless	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 - 117%	118 - 133%	134 - 159%	160 - 185%	186 - 200%	201 - 250%
Ambulatory Surgery	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600	$630
Inpatient Facility	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600	$630
Hospital Physician	$0	$7	$35	$55	$80	$110	$150	$195	$270	$300	$315
Emergency Room	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Emergency Transportation	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Outpatient Hospital Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35	$40
Clinic Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35	$40
Specialty Outpatient	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Prescription	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
Laboratory	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
Basic Radiology & Imaging	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
High-Level Radiology & Imaging	$0	$30	$90	$130	$185	$250	$335	$425	$580	$645	$680

There are different copayments for different service charges. The following information explains the different types of medical care charges and the related Client Copayments under the Standard Client Copayment Table.

1. Inpatient facility charges are for all non-physician (facility) services received by a Client while receiving care in the hospital setting for a continuous stay of 24 hours or longer.

2. Ambulatory Surgery charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a Client who is admitted to and discharged from the hospital setting on the same day. The Client is also responsible for the corresponding Hospital Physician charges.

3. Hospital Physician charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.

4. Clinic Services charges are for all non-physician (facility) and physician services received by a Client while receiving care in the outpatient clinic setting. Outpatient charges include primary and preventive medical care. This charge does not include radiology or laboratory services performed at the clinic.

5. Emergency Room charges are for all non-physician (facility) services received by a Client while receiving Emergency Care or Urgent Care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care).

6. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a Client while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Specialty Outpatient charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

7. Emergency Transportation charges are for transportation provided by an ambulance.

8. Laboratory Service charges are for all laboratory tests received by a Client while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.

9. Basic Radiology and Imaging Service charges are for all radiology and imaging services received by a Client while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.

10. Prescription charges are for prescription drugs received by a Client at a Qualified Health Care Provider's pharmacy as an outpatient service. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.

11. High-Level Radiology and Imaging Service charges are for Clients receiving a Magnetic Resonance Imaging, Computed Tomography, Positron Emission Tomography or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory in the outpatient hospital, emergency room, or clinic setting.

12. Outpatient Hospital Service charges are for all non-physician (facility) and physician services received by a Client while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Outpatient Hospital Services charges include primary and preventive medical care. This charge does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

13. Clients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

B. Homeless Clients, Clients living in transitional housing, "doubled-up" Clients, or recipients of Colorado's Aid to the Needy Disabled financial assistance program, who are at or below 40% of the Federal Poverty Level are exempt from Client Copayments.

1. Homeless Clients are exempt from Client Copayments, the income verification requirement, and providing proof of residency when completing the CICP application.

2. Transitional housing is designed to assist individuals in becoming self-supporting. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program. Transitional housing Clients are exempt from the income verification requirement when completing the CICP application.

3. Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the Client are considered doubled-up. The individual allowing the Client to reside with him or her may be asked to provide a written statement confirming that the Client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent.

4. Recipients of Colorado's Aid to the Needy Disabled financial assistance program are exempt from Client Copayments, and the income verification requirement when completing the CICP application.

C. Client Annual Copayment Cap

1. Homeless Clients whose financial determination is between 0 and 40% of the federal poverty level are exempt from copayments, so their copayment cap is $0. Clients whose financial determination is between 0 and 40% of the federal poverty level who are not homeless have a copayment cap that is the lesser of 10% of the family's net income or $120. Clients who are also Old Age Pension Health and Medical Care Program clients have a copayment cap of $300 as mandated by Section 8.941.10. For all other CICP Clients, annual copayments shall not exceed 10% of the family's financial determination.

2. Clients who are also Old Age Pension Health and Medical Care Program clients have annual copayment caps based on a calendar year. All other Client annual copayment caps (annual caps) are based on the Client's date of eligibility.

3. Clients are responsible for any charges incurred prior to the determination of the Client's financial eligibility.

4. Clients are responsible for tracking their CICP copayments and informing the provider in writing, including documentation, within 90 days after meeting or exceeding their annual cap. If a Client overpays the annual cap and informs the Qualified Health Care Provider of that fact in writing, the Qualified Health Care Provider shall reimburse the Client for the overpayment.

5. A CICP Client is eligible to receive a new determination if his or her financial or family situation has changed since the initial financial determination. CICP copayments made under the prior financial determination will not count toward a new CICP copayment cap and the Client's annual copayment cap resets when the Client completes a new application.

6. An annual cap applies only to charges incurred after a Client is eligible to receive discounted health care services and applies only to discounted services incurred at a CICP Qualified Health Care Provider, including services discounted under Hospital Discounted Care.

D. The Client must pay the lower of the copayment listed, the patient responsibility portion if the Client is insured, or actual charges. Payment plans must be offered to Clients and must follow the requirements set forth in Section 8.923 of the Hospital Discounted Care rule.

E. Clients shall be notified at or before time of services rendered of their copayment responsibility and available payment plan option.

F. Grants from foundations to Clients from non-profit, tax exempt, charitable foundations specifically for Client copayments are not considered other medical insurance or income. The provider shall honor these grants and may not count the grant as a resource or income.

8.920 Hospital Discounted Care

PURPOSE AND LEGAL BASIS

The Health Care Billing for Indigent Patients Act of 2021, C.R.S. § 25-3-501, et. seq., referred to as Hospital Discounted Care, establishes the maximum rate a Health Care Facility and Licensed Health Care Professional may bill low-income patients for Discounted Care provided in the hospital, requires written description of patient's rights, establishes patient appeals and complaint processes, and imposes requirements on hospitals before assigning or selling patient debt to a medical creditor or before pursuing collection action.

8.921 DEFINITIONS

A. Billing Statement means any patient-facing communication, whether electronic or in writing, that specifies an amount due for services and instructions for making payment.

B. Children's Basic Health Plan or the Child Health Plan Plus (CHP+) means the Children's Basic Health Plan as defined in Title 25.5, Article 8, C.R.S.

C. Colorado Indigent Care Program or CICP means the safety net program established in Title 25.5, Article 3, Part 1, C.R.S.

D. Department means the Department of Health Care Policy and Financing established pursuant to section 25.5-1-104, C.R.S.

E. Discounted Care means the amount a Provider may charge a Qualified Patient for Medically Necessary Health Care Services rendered.

F. Emergency Medicaid means short-term Medicaid coverage for eligible people who do not meet immigration or citizenship requirements for Medicaid and need treatment for life- and/or limb-threatening emergencies.

G. Federal Poverty Guidelines or FPG means a measure of income level issued annually by the United States Department of Health and Human Services. For Hospital Discounted Care, the FPG is updated annually every April 1.

H. Health Care Facility means a hospital licensed as a general hospital pursuant to Title 25, Article 3, Part 1, C.R.S., a hospital established pursuant to section 23-21-503, C.R.S. or section 25-29-103, C.R.S., any freestanding emergency department licensed pursuant to section 25-1.5-114, C.R.S., or any outpatient health care facility that is licensed as an on-campus department or service of a hospital or that is listed as an off-campus location under a hospital's license, but does not include a federally qualified health center as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x(aa)(4), or a student-learning medical or dental clinic that is established for the purpose of student learning, offering Discounted Care as part of a program of student learning that is physically situated within a health sciences school.

I. Health Care Services has the same meaning as set forth in section 10-16-102(33), C.R.S.

J. Impermissible Extraordinary Collection Action means initiating foreclosure on an individual's primary residence or homestead, including a mobile home, as defined in section 38-12-201.5(5), C.R.S.

K. Licensed Health Care Professional means any health care professional who is registered, certified, or licensed pursuant to Title 12, C.R.S. or who provides services under the supervision of a health care professional who is registered, certified, or licensed pursuant to Title 12, C.R.S. and who provides Health Care Services in a Health Care Facility.

L. Medicaid means the Colorado Medical Assistance Act set forth in Title 25.5, Articles 4, 5, and 6, C.R.S.

M. Medical Creditor means any entity that attempts to collect on a medical debt, including a Provider or Provider's billing office, a collection agency as defined in section 5-16-103(3), a debt buyer as defined in section 5-16-103(8.5), C.R.S. and a debt collector as defined in 15 U.S.C. sec. 1692a(6).

N. Non-CICP Health Care Services means Health Care Services provided in a Health Care Facility for which reimbursement under the Colorado Indigent Care Program, established in Title 25.5, Article 3, Part 1, C.R.S. is not available.

O. Patient Contact Best Efforts means the process of communication efforts completed by the Provider to contact a patient. This includes phone calls, SMS messages, emails, and portal messages.

P. Permissible Extraordinary Collection Action means an action other than an Impermissible Extraordinary Collection Action that requires a legal or judicial process, including but not limited to placing a lien on an individual's real property, attaching or seizing an individual's bank account or any other personal property, or garnishing an individual's wages. A Permissible Extraordinary Collection Action does not include the attachment of a hospital lien pursuant to section 38-27-101, C.R.S.

Q. Provider means any Health Care Facility or Licensed Health Care Professional subject to Title 25.5, Article 3, Part 5, C.R.S.

R. Qualified Patient means an individual who resides in Colorado, whose household income is not more than two hundred fifty percent of the Federal Poverty Level, and who received a Health Care Service at a Health Care Facility.

S. Screen or Screening means a process identified in rule by the Department whereby Health Care Facilities assess a patient's circumstances related to eligibility criteria and determine whether the patient is likely to qualify for public health care coverage or Discounted Care, inform the patient of the Health Care Facility's determination, and provide information to the patient about how the patient can enroll in public health care coverage.

T. SMS means short messaging service messages, commonly referred to as text messages

U. Uninsured means an uninsured individual, as defined in section 10-22-113(5)(d), C.R.S.

8.922 SCREENING AND APPLICATION

A. Screening, Application, and Determination Notice

1. Beginning September 1, 2022, using the single uniform application developed and distributed by the Department, a Health Care Facility shall screen each uninsured patient and any insured patients who request to be screened for:

a. Public health insurance programs including but not limited to Medicare, Medicaid, Emergency Medicaid, and the Children's Basic Health Plan.

b. Eligibility for the CICP, if the patient receives or is scheduled to receive a service eligible for reimbursement through the CICP.

c. Discounted Care, as described in section 25.5-3-503, C.R.S.

2. Uninsured Patients

a. Health Care Facilities must complete the screening process using the uniform application within 45 days from the uninsured patient's date of service or date of discharge, whichever is later.

b. The screening process consists of completing the first page of the uniform application using self-attested information provided by the patient or their guardian.

c. If the self-attested screening process results in a determination that the patient may be eligible for Discounted Care, then, at the time of the screening, the Health Care Facility must provide the patient or their guardian with a list of information and documents required to complete the application process. The patient is permitted 45 days to provide the documentation required to complete the application. When all necessary documentation has been received from the patient, the Health Care Facility must determine the patient's eligibility for Discounted Care and send written notice of the determination to the patient or guardian within 14 days.

d. If the self-attested screening process results in a determination that a patient likely is ineligible for Discounted Care, the patient must be informed that the screening results are not an official determination and that they have the right to complete the application and receive an official determination of eligibility for Discounted Care if they choose. If the patient requests to complete the application process for Discounted Care, the Health Care Facility must complete the application process and provide an official determination of eligibility for Discounted Care..

e. If the self-attested screening process results in a determination that the patient may be eligible for one or more public health coverage options, the Health Care Facility must inform the patient of those options and provide information on how the patient may apply for them, including any application deadlines the patient should be aware of.

3. Insured Patients

a. If the insured patient or their guardian requests to be screened for public health insurance programs, CICP, and Discounted Care, Health Care Facilities must screen insured patients within 45 days of their date of service or date of discharge, or within 45 days of the date of their first bill after their insurance adjustment, whichever is later.

b. The request to be screened may be made in person, by telephone, email, or by using the portal, if available. Health Care Facilities must contact the insured patient or their guardian to schedule the screening within three business days after receiving the insured patient's request.

c. Patients believed to have health insurance coverage when services were rendered and who are subsequently determined to be uninsured on their date of service are considered Uninsured. Within 45 days from the date of the notification that the patient was not insured on the date of service, the Health Care Facility must complete the screening.

4. Health Care Facility Determination Notice

a. The Health Care Facility must provide the patient written notice of the determination within 14 days of receiving all required documentation to complete the patient's application for Discounted Care. A copy of the determination must be sent to any and all applicable Licensed Health Care Professionals.

b. The determination shall be written in plain language and in the patient or their guardian's preferred language.

c. If a Health Care Facility fails to issue written notice of the determination to the patient within 14 days of receiving all required documentation to complete the patient's application, the patient may file an appeal. If the appeal is filed within 60 calendar days of the patient submitting all required documentation, the Health Care Facility must review the appeal and respond to the patient or their guardian and the Department within 15 calendar days of the date of the appeal.

d. For patients determined to be eligible for Discounted Care, the determination notice must include but is not limited to:

1. The programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, Hospital Discounted Care, and CICP, and the availability of subsidies through Connect for Health Colorado. This must also include where to find additional information and how to apply for each program the patient was determined potentially eligible for.

i. If the patient appears likely eligible for a program, and there is a deadline by which the patient must apply for to that program for their services to be covered, that date must be included in the determination notice.

2. The dates for which the Discounted Care determination is valid.

3. The household size and income used to determine eligibility and the household calculated FPG.

4. The patient's 4% and 2% limits based on their calculated gross household income.

5. If the patient was applying and approved for CICP, the patient's CICP rating.

6. If the patient was applying and approved for CICP, the patient's CICP copay cap.

7. If the Health Care Facility is not a CICP Provider, information on where the patient may obtain CICP services.

8. Information on how to file a complaint and how to file an appeal with the Health Care Facility and the Department.

e. The determination notice for patients determined not eligible for Discounted Care must include but is not limited to:

1. The basis for denial of Discounted Care.

2. The programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, and the availability of subsidies through Connect for Health Colorado. This must also include where to find additional information and how to apply for each program the patient was determined potentially eligible for.

i. If the patient appears likely eligible for a program, and there is a deadline by which the patient must apply to that program for their services to be covered, that date must be included in the determination notice.

3. The service date the Discounted Care denial covers and an explanation that the household may qualify for coverage of future services if there is a change in household size or income.

4. The household size and income used to determine eligibility and the household calculated FPG.

5. Information on how to file a complaint and how to file an appeal with the Health Care Facility and the Department.

5. A Health Care Facility is no longer obligated to screen an uninsured patient for past dates of service if the patient or their guardian signs the Decline Screening Form developed by the Department that notes those specific dates of service or a past date range that includes those specific dates of service except when a patient or guardian who opted out of screening subsequently requests to complete the screening, if the subsequent request is made prior to starting Permissible Extraordinary Collections Actions.

    a. The Health Care Facility must keep on file a Decline Screening Form signed by the patient, or their guardian until June 30 of the seventh state fiscal year after the patient's date of service or date of discharge, whichever is later.

6. For patients who are discharged without being screened or signing the Decline Screening Form, the Health Care Facility must attempt to contact the patient by at least one method of contact that the patient indicates is their preferred method, which can include phone call, SMS message, email, and portal message at least once a month for six months after the patient's date of discharge with the first contact sent prior to the expiration of 45 days after screening. The Health Care Facility may commence billing 46 days after the patient's date of service or date of discharge, whichever is later. If the patient requests that the Health Care Facility cease contacting them by phone, SMS message, or email, the provider may consider those requirements as fulfilled. The Health Care Facility must document the patient's request and maintain the request as part of the patient record.

7. If a Health Care Facility has attempted to contact the patient in accordance with Patient Contact Best Efforts, and the patient does not respond within 182 days of their date of service or date of discharge, whichever is later, the Facility may conclude that the patient has made an informed decision to decline screening. Patient Contact Best Efforts, at a minimum, must include:

    a. Notice that the failure to respond may result in the loss of their right to be screened for cost saving options.

    b. Calling any phone numbers provided by the patient and leaving voice messages with allowable information under the Health Insurance Portability and Accountability Act as defined at 45 C.F.R. sec. 164.502 and the Telephone Consumer Protection Act as defined at 47 U.S.C. sec. 227 if the calls are unanswered,

    c. SMS messages to any of the patient's phone numbers identified by the patient as a mobile number if the Health Care Facility has the ability to send SMS messages,

    d. Sending emails to any email address provided by the patient, and

    e. Sending messages through any appropriate patient portal.

8. If a patient does not indicate their preferred method of contact, the Provider shall contact patients in accordance with their internal patient communication policies. Documentation of the communication attempts for patients must be kept in their patient records and the communication policy must be kept on file until the June 30 of the seventh state fiscal year past the patient's date of service.

9. Documentation of the attempts to contact the patient or guardian to complete the screening must be maintained as part of the patient record. This may include call logs, message logs, copies of sent emails, portal messages sent, and copies of bills.

10. Providers shall maintain all Discounted Care-related records, including but not limited to, documentation to support screenings and determinations, service data including dates of service for Qualified Patients and services provided to them on those dates, and expenditures until June 30 of the seventh state fiscal year following the creation of the documentation.

B. Patients

1. Any patient or patient's guardian aged 18 and older may apply to receive Discounted Care.

2. The decision regarding eligibility for Discounted Care applies to both the patient and the members of the patient's household.

3. If a patient is deceased, the personal representative of the estate or a family member may complete the screening and application on behalf of the patient.

4. The application to receive Discounted Care shall include the names, birth dates, and relationship to the patient of all members of the patient's household who are included on the application.

   a. A patient must include their spouse or civil union partner in their household for the application.

   b. Any additional person living at the same address as the patient may also be included in the household.

   c. A patient may include household members who live in other states or countries if the patient attests to the fact that they provide at least 50% of the household member's support.

5. A minor shall not be screened separately from his or her parents or guardians unless they are emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Household Income

1. Using the information submitted by a patient or patient's guardian, the Health Care Facility shall determine whether the patient meets all requirements to receive Discounted Care. Health Care Facilities must follow the income counting methodology determined by the Department. Health Care Facilities shall determine Qualified Patient financial eligibility based on income from each household member 18 and older and household size. The Health Care Facility may not consider assets in determining eligibility.

2. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the patient or patient's guardian will be notified of the missing documentation within three business days after receipt of the application. An eligibility determination shall be made within 14 calendar days after the application is complete.

3. Patients may establish household income by providing documents that satisfy documentation guidelines established by the Department. Acceptable forms of documentation may include but is not limited to pay stubs, employer letter, tax returns, and business financial statements. The Health Care Facility may not require more than the minimum amount of documentation to substantiate declared income.

a. Patients who are experiencing homelessness are exempt from the documentation requirements related to establishing income and may self-attest to their household income.

8.923 HEALTH CARE SERVICE DISCOUNTS

A. Beginning September 1, 2022, if a patient screened pursuant to section 8.922 is determined to be a Qualified Patient, a Health Care Facility and a Licensed Health Care Professional shall:

1. Limit the amounts billed for Health Care Services to no more than the rate established in Department rule pursuant to section 8.929

2. Enter into a payment plan with the Qualified Patient in which the Qualified Patient pays for care in monthly installments. For services provided by a Health Care Facility, monthly installments shall not exceed four percent of the patient's gross monthly household income. For services provided by each Licensed Health Care Professional who bills separately from the Health Care Facility, monthly installments shall not exceed two percent of the patient's gross monthly household income; and

3. After a cumulative thirty-six months of payments, the Health Care Facility shall treat the Qualified Patient's bill as paid in full and must permanently cease collection activities on any balance that remains unpaid.

4. Providers shall not suggest or require that patients obtain loans that include fees, interest, or payment plans that exceed 36 payments to pay for services in lieu of setting up a payment plan directly with the Health Care Facility or Licensed Health Care Professional.

a. If a patient defaults on a loan from the Provider, the same rules apply related to any collection actions taken by the Provider as apply for payment plans under this section. If a patient defaults on a loan from the Provider, the same rules apply related to any collection actions taken by the Provider as apply for payment plans under this section.

B. A Health Care Facility shall not:

1. Deny Discounted Care on the basis that the patient has not applied for any public benefits program; or

2. Adopt or maintain any policies that result in the denial of admission or treatment of a patient because the patient may qualify for Discounted Care.

8.924 PATIENT RIGHTS

A. Beginning September 1, 2022, a Health Care Facility shall make available to the public and to each patient information developed by the Department about patient's rights pursuant to Part 5 of Article 3 of Title 25.5 C.R.S. (2021) and the uniform application developed by the Department pursuant to section 25.5-3-505 (2)(i), C.R.S.

B. At a minimum, the Health Care Facility shall:

1. Post the information in all languages spoken by ten percent or more of the population in any Colorado county conspicuously on the Health Care Facility's website, including a link to the information on the Health Care Facility's main landing page;

2. Make the information available in patient waiting areas;

3. Make the information available to each patient, or the patient's legal guardian, before the patient is discharged from the Health Care Facility, verbally or in writing in the patient's or legal guardian's preferred language, which may include using professional interpretation and/or translation services; and

4. Inform each patient on the patient's Billing Statement of the patient's rights pursuant to Part 5 of Article 3 of Title 25.5, C.R.S. (2021) including the right to apply for Discounted Care, and provide the website, email address, and telephone number where the information may be obtained in the patient's preferred language.

C. Providers shall not present the patient's rights in a format that differs from the format in which the material is distributed by the Department without Department approval.

1. Providers may not make any part of the patient's rights information part of a footnote or use any other format that may minimize its importance.

8.925 REPORTING REQUIREMENTS

A. Beginning September 1, 2023, and each September 1 thereafter, each Health Care Facility shall report to the Department data that the Department determines is necessary to evaluate compliance across race, ethnicity, age, and primary-language-spoken patient groups with the screening, Discounted Care, payment plan, and collections practices required by Title 25.5, Article 3, Part 5, C.R.S. . The Department shall distribute a compliance data reporting template to each Health Care Facility.

1. If a Health Care Facility is not capable of disaggregating the required data by race, ethnicity, age, and primary language spoken, the Health Care Facility shall report to the Department the steps the Health Care Facility is taking to improve race, ethnicity, age, and primary language spoken data collection and the date by which the facility will be able to disaggregate the reported data.

B. Beginning September 1, 2023 and each September 1 thereafter, each Health Care Facility shall submit Discounted Care utilization and charge data in a format and timeline determined by the Department.

8.926 COLLECTIONS

A. Beginning September 1, 2022, before assigning or selling patient debt to a collection agency or a debt buyer, or before pursuing, either directly or indirectly, any Permissible Extraordinary Collection Action:

1. A Health Care Facility shall meet the screening requirements in section 8.922;

2. A Provider shall provide Discounted Care to a Qualified Patient pursuant to section 8.920;

3. A Provider shall provide a plain language explanation of the health care services and fees and notify the patient or their guardian of potential collection actions in their preferred language on the timeline developed by the Department; and

4. A Provider shall bill any third-party payer that is responsible for providing health care coverage to the patient. If a Licensed Health Care Professional is an out-of-network provider under a Qualified Patient's health insurance plan, the Licensed Health Care Professional and health insurance carrier shall comply with the out-of-network billing requirements described in sections 10-16-704 (3) and 12-30-113, C.R.S.

B. A Health Care Facility must complete the Patient Contact Best Efforts in their attempts to contact a patient who has not signed a Decline Screening Form or who has not been screened as described in Section 8.922 prior to starting Permissible Extraordinary Collections Actions.

C. Documentation of Patient Contact Best Efforts communication attempts with the patient as outlined in section 8.922 satisfies the screening requirements for Health Care Facilities.

D. For a Qualified Patient with an established payment plan, Permissible Extraordinary Collections Actions may not be started until the patient has failed to remit three consecutive payments and has not communicated with the Provider asking for a deferment or to be redetermined prior to or during those three months of missed payments. Providers must notify Qualified Patients with established payment plans at least 30 days prior to the commencement of Permissible Extraordinary Collections Actions.

E. Providers shall not commence collection proceedings against a patient for any amount in excess of the rates established at Section 8.923.A.2, and must reduce the amount owed by the amount of any payments received from the patient or a third-party payer.

8.927 APPEALS AND COMPLAINTS

A. If a patient is determined ineligible for Discounted Care after the uniform application has been completed, the patient may appeal the decision as follows:

1. No later than 30 calendar days from the date on the Health Care Facility's eligibility determination letter, the patient or their guardian may submit an appeal in writing via U.S. Mail, email, or patient portal message if available to the Health Care Facility that made the determination.

2. Within 15 calendar days from the date of the appeal, the Health Care Facility shall complete a redetermination of eligibility and respond to the patient or guardian and the Department.

3. If the Health Care Facility upholds its initial eligibility determination, the patient or guardian may proceed to the next step of the appeals process as described in Section 8.927.A.4.

4. No later than 15 calendar days from the date of the Health Care Facility's initial appeal decision, the patient shall submit a written appeal to the Department. Email submissions must be addressed to hcpf_HospDiscountCare@state.co.us. Letters must be mailed to:

Department of Health Care Policy and Financing
Attention: Hospital Discounted Care
c/o State Programs Unit, Special Financing Division
1570 Grant Street
Denver, CO 80203

5. Within 15 calendar days from date of receipt of the appeal, the Department shall issue a final determination letter to both the patient and the Health Care Facility. If the Department deems that the redetermination was inaccurate, the Health Care Facility must resend a determination letter to the patient and the Department stating the patient is/was eligible for Discounted Care on the date of service.

B. A patient or guardian who believes a Health Care Facility has improperly calculated a payment plan based on inaccurate income information may appeal the payment plan offered by the Facility to the Department using the process described in Section 8.927.A.1.

C. The Department shall maintain records of all appeals and its final determinations for each Health Care Facility. If the Department determines a Health Care Facility has a repeated pattern of errors in patient eligibility determinations, the Department will require the Health Care Facility to attend training with the Department. The Health Care Facility may be subject to random application checks for 12 months following the training to ensure that the errors have been corrected.

D. Patients and their guardians may file complaints against Providers directly with the Department. Patients are not required to file a complaint with the Provider prior to filing a complaint with the Department.

1. Patients may submit complaints via U.S. Mail, email, or phone as follows:

Phone: 303-866-2580
Email: hcpf_HospDiscountCare@state.co.us
U.S. Mail: Department of Health Care Policy and Financing
Attention: Hospital Discounted Care
c/o State Programs Unit, Special Financing Division
1570 Grant Street
Denver, CO 80203

2. The Department shall review complaints within 30 calendar days of receipt.

3. The Department shall maintain records of all complaints for each Provider. If the Department determines there is a repeated pattern in the complaints filed against the Provider, the Provider may be subject to a corrective action plan.

a. Providers will have 90 days to submit a corrective action plan. Extensions may be made at the Department's discretion up to no more than 120 days.

8.928 REVIEW OF PROVIDERS FOR NONCOMPLIANCE

A. The Department shall periodically review Providers to ensure compliance with Part 5 of Article 3 of Title 25.5, C.R.S. (2021) and these rules. If the Department finds that a Provider is not in compliance with these rules, the Department shall notify the Provider.

B. The Provider will have 90 days to file a corrective action plan with the Department that must include measures to inform impacted patients about the noncompliance and provide financial corrections consistent with these rules.

1. At the Department's discretion, a Provider may be permitted up to 120 days to submit a corrective action plan upon request.

2. The Department may require a Provider that is not in compliance with Title 25.5, Article 3, Part 5, C.R.S. or these rules to develop and operate under a corrective action plan until the Department determines the Provider is in compliance.

C. If a Provider's noncompliance with these rules is determined by the Department to be knowing or willful or there is a repeated pattern of noncompliance, the Department may fine the Provider no more than $5,000. If the Provider fails to take corrective action or fails to file a corrective action plan with the Department pursuant to this section, the Department may fine the Provider no more than $5,000 per week until the Provider takes corrective action. The Department shall consider the size of the Health Care Facility and the seriousness of the violation in setting the fine amount.

D. The Department shall make the information reported pursuant to this section and any corrective action plans for which fines were imposed pursuant to this section available to the public and shall annually report the information as part of its presentation to its committees of reference at a hearing held pursuant to section 2-7-203 (2)(a), C.R.S. of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act".

E. For audit purposes, Providers shall maintain all Discounted Care related records, including but not limited to, documentation to support screenings and determinations, service data including dates of service for Qualified Patients and services provided to them on those dates, and expenditures until June 30 of the seventh state fiscal year following the screening or determination.

8.929 RATES

The Department shall annually establish rates for Discounted Care. The rates will approximate and not be less than one hundred percent of the Medicare rate or one hundred percent of the Medicaid rate, whichever is greater. The Department shall publicly post the established rates on the Department's website pursuant to section 25.5-3-505, C.R.S.

8.930 [Repealed effective 8/12/2011.]

8.940 OLD AGE PENSION HEALTH CARE PROGRAM

8.941 EXTENT AND LIMITATIONS OF MEDICAL CARE

8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM

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

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

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

1. Physician and practitioner services

2. Inpatient hospital

3. Outpatient services

4. Lab and x-ray

5. Emergency transportation

6. Emergency services

7. Dental

8. Pharmacy

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

9. Home health services and supplies

10. Medicare cost sharing

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

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

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

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

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

8.941.2 DEFINITIONS

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

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

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

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

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

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

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

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

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

8.941.3 GROUPS ASSISTED UNDER THE OLD AGE PENSION HEALTH CARE PROGRAM

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

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

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

8.941.4 FINANCIAL ASSISTANCE

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

8.941.5 CERTIFICATION OF PAYMENT FOR PROVIDERS

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

8.941.6 OUT-OF-STATE MEDICAL CARE

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

8.941.7 SUBMISSION OF CLAIMS

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

8.941.8 REIMBURSEMENT TO PROVIDERS

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

8.941.9 CLIENT CO-PAYMENT

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

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

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

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

8.942.1 MEDICAID QUALIFICATION

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

8.950 PRIMARY CARE FUND

8.950.1 GENERAL DESCRIPTION

8.950.1.A. In accordance with Section 21 of Article X (Tobacco Taxes for Health Related Purposes) of the State Constitution, an increase in Colorado's tax on cigarettes and tobacco products became effective January 1, 2005, and created a cash fund that was designated for health related purposes. House Bill 05-1262 divided the tobacco tax cash fund into separate funds, assigning 19% of the moneys to establish the Primary Care Fund, set forth how the funds will be allocated and designated the Department of Health Care Policy and Financing (the Department) as the administrator of the Primary Care Fund.

8.950.1.B. The Primary Care Fund provides an allocation of moneys to health care providers that make basic health care services available in an outpatient setting to residents of Colorado who are considered medically indigent. Moneys shall be allocated based on the number of medically indigent patients in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for moneys from this fund.

8.950.2 DEFINITIONS

8.950.2.A. Arranges For - Demonstrating Established Referral Relationships with health care providers for any of the Comprehensive Primary Care services not directly provided by the provider.

8.950.2.B. Children's Basic Health Plan also known as Child Health Plan Plus (CHP+) - As specified in Article 19 of Title 26, C.R.S.

8.950.2.C. Colorado Indigent Care Program (CICP) - As specified in Article 15 of Title 26, C.R.S.

8.950.2.D. Comprehensive Primary Care - Basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting. At a minimum, this includes providing or arranging for the provision of the following services on a Year-Round Basis: primary health care; maternity care, including prenatal care; preventive, developmental, and diagnostic services for infants and children; adult preventive services, diagnostic laboratory and radiology services; emergency care for minor trauma; Pharmaceutical Services; and coordination and follow-up for hospital care. It may also include optional services based on a patient's needs such as dental, behavioral health and eyeglasses.

8.950.2.E. Cost-Effective Care - Provides or Arranges for Comprehensive Primary Care that is appropriate and at a reasonable average cost per patient Visit and/or Encounter.

8.950.2.F. Eligible Qualified Provider - A qualified Provider who is identified by the Department to receive funding from the Primary Care Fund.

8.950.2.G. Established Referral Relationship - A formal, written agreement in the form of a letter, a memorandum of agreement or a contract between two entities which includes:

1. The Comprehensive Primary Care and/or products (e.g., pharmaceuticals, radiology) to be provided by one entity on behalf of the other entity;

2. Any applicable policies, processes or procedures;

3. The guarantee that referred Medically Indigent Patients shall receive services on a Sliding Fee Schedule or at no charge; and

4. Signatures by representatives of both entities.

8.950.2.H. Medical Assistance Program (Medicaid) - As specified in Article 4 of Title 26, C.R.S.

8.950.2.I. Medically Indigent Patient - A patient receiving medical services from a Qualified Provider:

1. Whose yearly family income is below two hundred percent (200%) of the Federal Poverty Level (FPL);

2. Who is not eligible for the Medical Assistance Program, , the Children's Basic Health Plan, Medicare or any other governmental reimbursement for health care costs such as through Social Security, the Veterans Administration, Military Dependency (TRICARE or CHAMPUS), or the United States Public Health Service. (Payments received from the Colorado Indigent Care Program are not considered a governmental reimbursement for health care costs related to a specific patient); and

3. There is no Third Party Payer.

8.950.2.J. Medically Underserved Area - A federal government designation given to a geographical area based on the ratio of medical personnel (physicians, dentists, behavioral health workers, etc.) to the population. These areas have fewer than a generally accepted minimum number of medical personnel per thousand population resulting in insufficient health resources (personnel and/or facilities) to meet the medical needs of the resident population. Such areas are also defined by measuring the health status of the resident population; an area with an unhealthy population being considered underserved.

8.950.2.K. Medically Underserved Population - A federal government designation given to a human population that does not receive adequate medical attention or have access to health care facilities.

8.950.2.L. Outside Entity - A business or professional that is not classified as an employee of the provider or the Department and does not have a direct or indirect financial interest with the provider. The business or professional shall have auditing experience or experience working directly with the Medical Assistance Program or similar services or grants for Medically Indigent Patients.

8.950.2.M. Pharmaceutical Services - Provides prescription drugs, or coordinates access to or Arranges For client to receive prescription drugs prescribed by the Qualified Provider on a Sliding Fee Schedule or at no charge.

8.950.2.N. Qualified Provider - An entity that provides Comprehensive Primary Care in Colorado and that:

1. Accepts all patients regardless of their ability to pay and uses a Sliding Fee Schedule for payments or does not charge Medically Indigent Patients for services;

2. Serves a designated Medically Underserved Area or Medically Underserved Population as provided in section 330(b) of the federal "Public Health Service Act", 42 U.S.C. sec. 254b, or demonstrates to the Department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons;

3. Has a demonstrated Track Record of providing Cost-Effective Care;

4. Provides or Arranges For the provision of Comprehensive Primary Care to persons of all ages. An entity in a rural area may be exempt from this requirement if they can demonstrate that there are no providers in the community to provide one or more of the Comprehensive Primary Care services;

5. Completes a screening that evaluates eligibility for the Medical Assistance Program, the Children's Basic Health Plan, and the Colorado Indigent Care Program and refers patients potentially eligible for one of the programs to the appropriate agency (e.g., county departments of human/social services) for eligibility determination if they are not qualified to make eligibility determinations; and

6. Is a community health center, as defined in Section 330 of the federal "Public Health Services Act", 42 U.S.C. Section 254b; or at least 50% of the patients served by the provider are Medically Indigent Patients or patients who are enrolled in the Medical Assistance Program, the Children's Basic Health Plan, or any combination thereof.

8.950.2.O. Quality Assurance Program - Formalized plan and processes designed to ensure the delivery of quality and appropriate Comprehensive Primary Care in a defined medical setting. This can be demonstrated by obtaining a certification or accreditation through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). If such certification or accreditation is not available, then at a minimum, the Quality Assurance Program shall be comprised of elements that meet or exceed the following components:

1. Establishment of credentialing/re-credentialing requirements for medical personnel;

2. Surveying and monitoring of patient satisfaction;

3. Establishment of a grievance process for patients, including documentation of grievances and resolutions;

4. Development of clinic operating policies and scheduled performance monitoring;

5. Review of medical records to check for compliance with established policies and to monitor quality of care;

6. Assessment of state and federal regulations to ensure compliance;

7. Establishment of patient safety procedures; and

8. Establishment of infection control practices.

8.950.2.P. Sliding Fee Schedule - A tiered co-payment system that determines the level of patient's financial participation and guarantees that the patient financial participation is below usual and customary charges. Factors considered in establishing the tiered co-payment system shall only be financial status and the number of members in the patient's family unit.

8.950.2.Q. Third Party Payments or Third Party Payer - Any individual, entity or program with a legal obligation to pay for some or all health-related services rendered to a patient. Examples include the Medical Assistance Program; the Children's Basic Health Plan; Medicare; commercial, individual or employment-related health insurance; court-ordered health insurance (such as that required by non-custodial parents); workers' compensation; automobile insurance; and long-term care insurance. The Colorado Indigent Care Program is not considered a Third Party Payer and payments received from the Colorado Indigent Care Program are not considered Third Party Payments.

8.950.2.R. Track Record - Evidence of providing Comprehensive Primary Care covering at least a consecutive 52-week period prior to the submission of the application.

8.950.2.S. Unduplicated User/Patient Count - The sum of patients who have had at least one Visit/Encounter and received at least one of the services under the Comprehensive Primary Care definition during the applicable calendar year, but does not include the same patient more than once. The sum shall be calculated on a specific point-in-time occurring between the end of the applicable calendar year and prior to the submission of the application. Each patient shall be counted once under only one payment source designation (Third Party Payer or Medically Indigent Patient). The patient's payment source designation shall be the payment source designation listed for the patient at the specific point-in-time in which the calculation is made. The sum shall not include:

1. Counting a patient more than once if the same patient returns for additional services (e.g., medical or dental) and/or products (e.g., pharmaceuticals) during the applicable calendar year;

2. Counting a patient more than once if the payment source designation changed during the applicable calendar year;

3. Persons who have only received services through an outreach event, community education program, nurse hotline, or other types of community-based events or programs and were not documented on an individual basis;

4. Persons who have only received services from large-scale efforts such as mass immunization programs, screening programs, and health fairs; or

5. Persons whose only contact with the provider is to receive Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) counseling and vouchers are not users and the contact does not generate an encounter.

8.950.2.T. Visit/Encounter - An appointment with medical personnel (physicians, physician assistants, dentists, behavioral health workers, etc.) in which the patient received health related services and/or products (e.g., pharmaceuticals or radiology) and the appointment is customarily billable to a Third Party Payer.

8.950.2.U. Year-Round Basis - Comprehensive Primary Care provided in a consecutive 52-week period directly by the provider and/or through an established referral relationship with other providers. If an organization is closed for four consecutive weeks or longer in a calendar year on a regularly scheduled basis, it is not considered to directly provide services on a year-round basis.

8.950.3 PROVIDER ELIGIBILITY

8.950.3.A. Providers who provide Comprehensive Primary Care to Medically Indigent Patients and who meet all of the requirements established for the Primary Care Fund as of the date the application form is submitted to the Department shall receive moneys appropriated to the Primary Care Fund. Specifically, the provider shall:

1. Meet all of the requirements of a Qualified Provider as specified in 8.950.2.N;

2. Have a Quality Assurance Program in place as specified in 8.950.2.O; and

3. Submit a completed application form according to stated guidelines as specified under 8.950.4.

8.950.4 APPLICATION

8.950.4.A. The application form shall be available to providers annually and posted for public access on the Department's website at least 30 calendar days prior to the response due date.

8.950.4.B. At a minimum, the application form shall require responses that:

1. Demonstrate how the provider meets the criteria of a Qualified Provider as defined in 8.950.2.N;

2. Provide an Unduplicated User/Patient Count covering the applicable calendar year which, at a minimum, shall include the number of patients eligible for the Medical Assistance Program and the Children’s Basic Health Plan and the number of patients considered to be Medically Indigent Patients;

3. Provide certification that the Unduplicated User/Patient Count identified in 8.950.4.B.2 has been verified by an Outside Entity; and

4. Provide documentation that the provider has a Quality Assurance Program as defined in 8.950.2.O.

8.950.4.C. Providers shall complete and provide a response annually. The response shall be made in compliance with all specifications in the application form, including format, data and documentation. Responses to the application form shall be submitted directly to the Department by the required response deadline.

8.950.4.D. All providers who submit a response to the application form shall be notified within 45 days of the response deadline if the provider met or did not meet the requirements to become an Eligible Qualified Provider.

8.950.5 DISBURSEMENT

8.950.5.A. Eligible Qualified Providers are determined on a state fiscal year basis and shall receive only those moneys appropriated to the Primary Care Fund for that same state fiscal year, subject to the tax amount actually collected for that state fiscal year.

8.950.5.B. Payments shall be based on the number of Medically Indigent Patients in each Eligible Qualified Provider's Unduplicated User/Patient Count in an amount proportionate to the total number of Medically Indigent Patients from all Eligible Qualified Providers' Unduplicated User/Patient Counts.

8.950.5.C. The schedule for the disbursement of moneys to all Eligible Qualified Providers shall be dependent on actual tax collections allocated to the Primary Care Fund such that:

1. Tax collections for sales in July, August, and September shall be distributed to Eligible Qualified Providers prior to the end of October.

2. Tax collections for sales in October, November, and December shall be distributed to Eligible Qualified Providers prior to the end of January.

3. Tax collections for sales in January, February, and March shall be distributed to Eligible Qualified Providers prior to the end of April.

4. Tax collections for sales in April, May, and June shall be distributed to Eligible Qualified Providers prior to the end of July.

5. For State Fiscal Year 2005-06 only, tax collections for sales in January 2005 through December 2005, shall be distributed to Eligible Qualified Providers prior to the end of February 2006.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.1 Definitions

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

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

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

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

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

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

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

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

Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior or client is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. A community-based organization or foundation;

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

4. A local public health agency; or

5. A private dental practice.

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

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

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

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

8.960.2 Legal Basis

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

8.960.3 Request of Grant Proposals and Grant Award Procedures

8.960.3.A Request for Grant Proposals

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

8.960.3.B Evaluation of Grant Proposals

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

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

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

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

    a. Outreach to and identify Eligible Seniors;

    b. Collaborate with community-based organizations; and

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

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

8.960.3.C Grant Awards

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

8.960.3.D Qualified Grantee Responsibilities

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

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

2. Demonstrate collaboration with community-based organizations;

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

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

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

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

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

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

8.960.3.E Invoicing

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

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

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

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

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

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

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

8.960.3.F Annual Report

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

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

1. The number of Eligible Seniors served;

2. The types of Covered Dental Care Services provided;

3. An itemization of administrative expenditures;

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

5. Any other information deemed relevant by the Department.

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

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

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

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - periapical each additional radiographic image	D0230	$23.00	$23.00	$0.00	D0230 must be utilized for additional films taken beyond D0220. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.
Bitewing - single radiographic image	D0270	$26.00	$26.00	$0.00	Frequency: 1 in a 12 month period. Report more than 1 radiographic image as: D0272 two (2); D0273 three (3); D0274 four (4). Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - two radiographic images	D0272	$42.00	$42.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - three radiographic images	D0273	$52.00	$52.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Bitewings - four radiographic images	D0274	$60.00	$60.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Vertical bitewings – seven to eight radiographic images	D0277	$68.32	$68.32	$0.00	Frequency: 1 time in a 12-month period. This does not constitute a full mouth intraoral radiographic series. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Panoramic radiographic image	D0330	$63.00	$63.00	$0.00	Frequency: 1 per 5 years per client. Cannot be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 years.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Prophylaxis - adult	D1110	$88.00	$88.00	$0.00	Removal of plaque, calculus and stains from the tooth structures with intent to control local irritational factors. Frequency: • 1 time per 6 calendar months; 2 week window accepted. • May be billed for routine prophylaxis. • D1110 may be billed with D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth not receiving nonsurgical periodontal therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease. D1110 can only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed. • May be alternated with D4910 for maintenance of periodontally-involved individuals. • D1110 cannot be billed on the same day as D4346 • Cannot be used as 1 month re-evaluation following nonsurgical periodontal therapy.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Topical application of fluoride varnish	D1206	$52.00	$52.00	$0.00	Topical fluoride application is to be used in conjunction with prophylaxis or preventive appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. Cannot be used with D1208.
Topical application of fluoride - excluding varnish	D1208	$52.00	$52.00	$0.00	Any fluoride application, including swishing, trays or paint on variety, to be used in conjunction with prophylaxis or preventive appointment. Frequency: one (1) time per 12 calendar months. Cannot be used with D1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
Interim caries arresting medicament application – per tooth	D1354	$5.71	$5.71	$0.00	Two of D1354 per 12 months per patient per tooth for primary and permanent teeth. Not to exceed 4 times per tooth in a lifetime. Cannot be billed on the same day as D1355 or any D2000 series code (D2140–D2954). Must Report both tooth number and surface(s).

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Caries preventive medicament application – per tooth	D1355	$5.47	$5.47	$0.00	For primary prevention or remineralization. Medicaments applied do not include topical fluorides. Medicaments that may be applied during the delivery of D1355 procedure include Silver Diamine Fluoride (SDF), Silver Nitrate (SN), thymol-CHX varnish, and topical povidone iodine (PVP-I). Cannot be billed on the same day as: D1206, D1208, D1354, D0140, D9110, or any restoration codes on the same day or within 12 months of D2140 thru D2954. Maximum of four D1355 per tooth per lifetime. Must report both tooth number and surface(s).
Amalgam - one surface, primary or permanent	D2140	$112.67	$102.67	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - two surfaces, primary or permanent	D2150	$141.20	$131.20	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - three surfaces, primary or permanent	D2160	$170.88	$160.88	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - four or more surfaces, primary or permanent	D2161	$204.96	$194.96	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Resin-based composite - one surface, anterior	D2330	$115.00	$105.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - two surfaces, anterior	D2331	$146.00	$136.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	$179.00	$169.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	$212.00	$202.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, posterior	D2391	$134.00	$124.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite -two surfaces, posterior	D2392	$176.00	$166.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	$218.00	$208.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Resin-based composite - four or more surfaces, posterior	D2394	$268.00	$258.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Crown - porcelain/ceramic	D2740	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to high noble metal	D2750	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to predominantly base metal	D2751	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	$87.00	$77.00	$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	$89.00	$79.00	$10.00	Not allowed within 6 months of placement.
Core buildup, including any pins when required	D2950	$225.00	$200.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. Not payable on the same tooth and same day as D2951.
Pin retention per tooth	D2951	$50.00	$40.00	$10.00	Pins placed to aid in retention of restoration. Can only be used in combination with a multi-surface amalgam.
Cast post and core in addition to crown	D2952	$332.00	$307.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Prefabricated post and core in addition to crown	D2954	$269.00	$244.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Core is built around a prefabricated post. This procedure includes the core material and refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.

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

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	D4346	$102.00	$92.00	$10.00	The removal of plaque, calculus, and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures. Frequency: once in a lifetime. • Any follow-up and re-evaluation are included in the initial reimbursement. • Cannot be charged on the same date as D1110, D4341, D4342, or D4910.
Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit	D4355	$94.02	$84.02	$10.00	One of (D4335) per 3 year(s) per patient. Prophylaxis D1110 is not reimbursable when provided on the same day of service as D4355. D4355 is not reimbursable if patient record indicates D1110 or D4910 have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as D4355.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal maintenance procedures	D4910	$136.00	$136.00	$0.00	Procedure following periodontal therapy D4341 or D4342. This procedure includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. Frequency: • Up to four times per fiscal year per client. • Cannot be charged on the same date as D4346. • Cannot be charged within the first three months following active periodontal treatment.
Complete denture - maxillary	D5110	$874.52	$794.52	$80.00	Reimbursement made upon delivery of a complete maxillary denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130 or D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	$875.94	$795.94	$80.00	Reimbursement made upon delivery of a complete mandibular denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130, D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – maxillary	D5130	$874.52	$794.52	$80.00	Reimbursement made upon delivery of an immediate maxillary denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5130 can be reimbursed only once per lifetime per client. Complete denture, D5110, may be considered 5 years after immediate denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.
Immediate denture – mandibular	D5140	$875.94	$795.94	$80.00	Reimbursement made upon delivery of an immediate mandibular denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5140 can be reimbursed only once per lifetime per client. Complete dentures, D5120, may be considered 5 years after immediate denture was reimbursed – documentation that existing prosthesis cannot be made serviceable must be maintained.

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213	$844.31	$784.31	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can also be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	$844.31	$784.31	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	D5221	$607.61	$547.61	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5221 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	D5222	$607.61	$547.61	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5222 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5223	$844.31	$784.31	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5223 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5224	$844.31	$784.31	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5224 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.
Repair broken complete denture base, mandibular	D5511	$123.70	$113.70	$10.00	Repair broken complete denture base, mandibular
Repair broken complete denture base, maxillary	D5512	$123.70	$113.70	$10.00	Repair broken complete denture base, maxillary
Replace missing or broken teeth - complete denture (each tooth)	D5520	$92.91	$82.91	$10.00	Replacement/repair of missing or broken teeth.
Repair resin partial denture base, mandibular	D5611	$95.00	$85.00	$10.00	Repair resin partial denture base, mandibular
Repair resin partial denture base, maxillary	D5612	$95.00	$85.00	$10.00	Repair resin partial denture base, maxillary
Repair cast partial framework, mandibular	D5621	$121.29	$111.29	$10.00	Repair cast partial framework, mandibular
Repair cast partial framework, maxillary	D5622	$121.29	$111.29	$10.00	Repair cast partial framework, maxillary
Repair or replace broken retentive/clasping materials – per tooth	D5630	$131.00	$121.00	$10.00	Repair of broken clasp on partial denture base – per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Replace broken teeth-per tooth	D5640	$94.02	$84.02	$10.00	Repair/replacement of missing tooth.
Add tooth to existing partial denture	D5650	$109.00	$99.00	$10.00	Adding tooth to partial denture base. Documentation may be requested when charged on partial delivered in last 12 months.
Add clasp to existing partial denture	D5660	$136.05	$126.05	$10.00	Adding clasp to partial denture base – per tooth. Documentation may be requested when charged on partial delivered in last 12 months.
Rebase complete maxillary denture	D5710	$322.00	$297.00	$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase complete mandibular denture	D5711	$322.00	$297.00	$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase maxillary partial denture	D5720	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Rebase mandibular partial denture	D5721	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Reline complete maxillary denture (chairside)	D5730	$182.00	$172.00	$10.00	Chair side reline that resurfaces without processing denture base. Frequency: One (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (chairside)	D5731	$182.00	$172.00	$10.00	Chair side reline that resurfaces without processing denture base. Frequency: One (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (chairside)	D5740	$175.82	$165.82	$10.00	Chair side reline that resurfaces without processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (chairside)	D5741	$177.49	$167.49	$10.00	Chair side reline that resurfaces without processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Reline complete maxillary denture (laboratory)	D5750	$243.00	$218.00	$25.00	Laboratory reline that resurfaces with processing denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (laboratory)	D5751	$243.00	$218.00	$25.00	Laboratory reline that resurfaces with processing denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (laboratory)	D5760	$239.00	$214.00	$25.00	Laboratory reline that resurfaces with processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (laboratory)	D5761	$239.00	$214.00	$25.00	Laboratory reline that resurfaces with processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	$111.78	$101.78	$10.00	Routine removal of tooth structure, including minor smoothing of socket bone, and closure as necessary. Treatment notes must include documentation that an extraction was done per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$172.88	$162.88	$10.00	Includes removal of bone, and/or sectioning of erupted tooth, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth.
Removal of impacted tooth-soft tissue	D7220	$207.25	$187.25	$20.00	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32 One of D7220 per 1 lifetime per patient per tooth
Removal of impacted tooth-partially bony	D7230	$255.53	$235.53	$20.00	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32 One of D7230 per 1 lifetime per patient per tooth
Removal of impacted tooth-completely bony	D7240	$296.38	$276.38	$20.00	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32 One of D7240 per 1 lifetime per patient per tooth.
Removal of impacted tooth-completely boney, with unusual surgical complications	D7241	$389.20	$369.20	$20.00	Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Teeth 1-32 One of D7241 per lifetime per patient per tooth.
Surgical removal of residual tooth roots (cutting procedure)	D7250	$182.30	$172.30	$10.00	Includes removal of bone, and/or sectioning of residual tooth roots, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth. Can only be charged once per tooth. Cannot be charged for removal of broken off roots for recently extracted tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Primary closure of a sinus perforation	D7261	$452.46	$442.46	$10.00	Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fisulous 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-soft	D7286	$381.00	$381.00	$0.00	Removing tissue for histologic evaluation. Treatment notes must include documentation and proof that biopsy was sent for evaluation.
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	$150.00	$140.00	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	$139.42	$129.42	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	$200.47	$190.47	$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	$200.47	$190.47	$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Removal of lateral exostosis (maxilla or mandible)	D7471	$290.11	$280.11	$10.00	Removal of a benign bony outgrowth (bone spur) for proper prosthesis fabrication. Reported per arch.
Removal of torus palatinus	D7472	$341.08	$331.08	$10.00	To remove a malformation of bone for proper prosthesis fabrication.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of torus mandibularis	D7473	$332.69	$322.69	$10.00	To remove a malformation of bone for proper prosthesis fabrication.
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins.
Palliative (emergency) treatment of dental pain - minor procedure	D9110	$78.23	$53.23	$25.00	Emergency treatment to alleviate pain/discomfort. This code cannot be used for filing claims or writing or calling in a prescription to the pharmacy or to address situations that arise during multi-visit treatments covered by a single fee such as surgical or endodontic treatment. Report per visit, no procedure. Frequency: Limit 1 time per year. Maintain documentation that specifies problem and treatment.
Evaluation for moderate sedation, deep sedation or general anesthesia	D9219	$40.90	$40.90	$0.00	One of D9219 or D9310 per 12 month(s) per provider or location
Deep sedation/general anesthesia-each 15 minute increment	D9223	$103.40	$93.40	$10.00	Ten of D9223 per 1 day per patient. Not allowed with D9243
Intravenous moderate (conscious) sedation/analgesia-first 15 minutes	D9239	$109.23	$99.23	$10.00	One of D9239 per 1 day per patient.
Intravenous moderate (conscious)sedation/analgesia-each 15 minute increment	D9243	$103.40	$93.40	$10.00	Fourteen of D9243 per 1 day per patient. Not allowed with D9223

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

Posterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Occlusal, Lingual, or Buccal.
	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial-Occlusal.
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual-Occlusal-Distal.
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Occlusal-Lingual-Distal.

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

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

EDITOR'S NOTES

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 03/04/2007, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 03/04/2007, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]