

Title of Rule: Revision of Medical Assistance Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201  
Rule Number: MSB 14-11-19-A  
Division / Contact / Phone: Medicaid Programs and Services / Sarah Tilleman / 4623

**STATEMENT OF BASIS AND PURPOSE**

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

The Department is amending the adult dental rule in order to better define amount, scope and duration. The rule amendment is designed to increase access for adults and to reduce burden on providers. The Department is also correcting typos and other technical errors.

2. An emergency rule-making is imperatively necessary

to comply with state or federal law or federal regulation and/or

for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

§1905(a)(10) of the Social Security Act.

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2012);  
§ 25.5-5-202(1)(w), C.R.S. (2013); § 25.5-5-207, C.R.S. (2014) .

Initial Review **02/13/2015**  
Proposed Effective Date **05/01/2015**

Final Adoption **03/13/2015**  
Emergency Adoption

**DOCUMENT #05**

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## REGULATORY ANALYSIS

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

This rule amendment will affect Medicaid dental providers and Medicaid eligible clients age 21 years and older.

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

Research has shown that untreated oral health conditions negatively affect a person's overall health and that gum disease has been linked to diabetes, heart disease, strokes, kidney disease, Alzheimer's disease, and even mental illness. Regular dental care and prevention are the most cost-effective methods available to prevent minor oral conditions from developing into more complex oral and physical health conditions that would eventually require emergency and palliative care.

Clearly defined and updated rules will improve client access to appropriate, high quality, cost-effective and evidence-based services while improving the health outcomes of Medicaid clients. Established criteria within the rule will provide guidance to clients and providers regarding benefit coverage. For example, in the case of dental, this rule will help ensure providers are knowledgeable of Medicaid coverage through the transparency of guidance available in the rule changes. Medicaid covered residents will also be better served with clear transparent description of the dental benefit. Medicaid covered residents and Medicaid dental providers will experience reductions in administrative barriers due to the removal of unnecessary prior authorizations for certain services, in-line with industry norms and standards regarding utilization management.

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

Dental benefits will be capped at \$1,000 per client. The fiscal note that accompanied SB 13-242 assumes that clients will use an average of \$627 in dental benefits per year. Of the eligible population, The Department estimates approximately 27 percent of eligible clients will use dental benefits, which is prorated in the first year. As a result, caseload is estimated at 43,043 in FY 2013-14 and 82,072 in FY 2014-15.

Total adult dental benefit costs are \$28.8 million in FY 2013-14 and \$58.8 million in FY 2014-15. However, a portion of the adult dental benefit costs are assumed to be offset by reduced

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emergency dental services. The fiscal note assumes savings of 15 percent, or \$1.9 million, in FY 2013-14 and 30 percent, or \$4.0 million, in FY 2014-15

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

Clearly defined and updated rules increase client access to appropriate services and allow the Department to administer benefits in compliance with federal and state regulations, as well as clinical best practices and quality standards. Defining this benefit in rule will educate clients about their benefits and provide better guidance to service providers. The cost of inaction could result in decreased access to services, poor quality of care, and/or lack of compliance with state and federal guidance.

All of the above translates into appropriate cost-effective care administered by the state.

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

There are no less costly methods or less intrusive methods for achieving the purpose of this rule. The department must appropriately define amount, scope and duration of this benefit in order to responsibly manage it.

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

The Department also documents its benefit coverage policies in written coverage standards. The benefit coverage policies must be written into rule to have the force of rule.

1 **8.201 ADULT DENTAL SERVICES**

2 **8.201.1 DEFINITIONS**

3 Adult Client means an individual who is 21 years or older and eligible for medical assistance benefits.

4 ~~Cleaning is the removal of dental plaque and calculus for teeth, in order to prevent dental caries, gingivitis~~  
5 ~~and periodontis.~~

6 Comprehensive Oral Evaluation – New or Established Patient means a thorough evaluation and  
7 documentation of a client's dental and medical history to include extra-oral and intra-oral hard and soft  
8 tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal  
9 conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening, as  
10 defined by the Current Dental Terminology (CDT)-(2014).

11 Comprehensive Periodontal Evaluation means the procedure that is indicated for patients showing signs  
12 or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It  
13 includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the  
14 patient's dental and medical history and general health assessment. It may include the evaluation and  
15 recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer  
16 evaluation, as defined by the Current Dental Terminology (CDT)-(2014).

17 Dental Caries is a common chronic infectious transmissible disease resulting from tooth-adherent specific  
18 bacteria that metabolize sugars to produce acid which demineralizes tooth structure over time (tooth  
19 decay).

20 Dental professional means a licensed dentist or dental hygienist enrolled with Colorado Medicaid.

21 Detailed and Extensive Oral Evaluation – Problem Focused, By Report means a detailed and extensive  
22 problem focused evaluation entailing extensive diagnostic and cognitive modalities based on the findings  
23 of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a  
24 treatment plan for a specific problem is required. The condition requiring this type of evaluation should all  
25 be described and documented. Examples of conditions requiring this type of evaluation may include  
26 dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction,  
27 facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc., as defined by the  
28 Current Dental Terminology (CDT)-(2014).

29 Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of  
30 diagnostic evaluation, as defined by the Current Dental Terminology (CDT)-(2014).

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

33 Emergency Services means the need for immediate intervention by a physician, osteopath or dental  
34 professional to stabilize an oral cavity condition. ~~Immediate Intervention or Treatment means services~~  
35 ~~rendered within twelve (12) hours.~~

36 Evaluation means a patient assessment that may include gathering of information through interview,  
37 observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions,  
38 as defined by the Current Dental Terminology (CDT)-(2014).

39 High Risk of Caries is indicated in Adult Clients who present with demonstrable caries, a history of  
40 restorative treatment, dental plaque, and enamel demineralization.

1 Immediate Intervention or Treatment is when a patient presents with symptoms and/or complaints of pain,  
2 infection or other conditions that would require immediate attention.

3 Limited Oral Evaluation – Problem Focused means an evaluation limited to a specific oral health problem  
4 or complaint, as defined by the Current Dental Terminology (CDT) (2014).

5 Oral Cavity means the jaw, mouth or any structure contiguous to the jaw.

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

8 Periodic Oral Evaluation means an evaluation performed on a client of record to determine any changes  
9 in the patient's dental and medical status since a previous comprehensive or periodic evaluation. This  
10 includes an oral cancer evaluation and periodontal screening where indicated, and may require  
11 interpretation of information acquired through additional diagnostic procedures, as defined by the Current  
12 Dental Terminology (CDT) (2014).

13 Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal (gum) disease  
14 progression.

15 Preventive services means services concerned with promoting good oral health and function by  
16 preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence  
17 of oro-facial injuries, as defined by the Current Dental Terminology (CDT) (2014).

18 Prophylaxis (Cleaning) is the removal of dental plaque and calculus from teeth, in order to prevent  
19 dental caries, gingivitis and periodontitis.

20 Re-Evaluation - Limited, Problem Focused (Established Patient; Not Post-Operative Visit) means  
21 assessing the status of a previously existing condition. For example, a traumatic injury where no  
22 treatment was rendered but patient needs follow-up monitoring,; an evaluation for undiagnosed  
23 continuing pain,; or a soft tissue lesion requiring follow-up evaluation, as defined by the Current Dental  
24 Terminology (CDT) (2014).

25 Restorative means services rendered for the purpose of rehabilitation of dentition to functional or  
26 aesthetic requirements of the client, as defined by the Current Dental Terminology (CDT) (2014).

27 Year begins on the date of service.

28 **8.201.2 BENEFITS**

29 8.201.2.A Covered Services

30 ~~4.~~ 1. Covered Evaluation Procedures:

31 a. Periodic Oral Evaluation;

32 i. shall be limited to two (2) per years.

33 ii. Is limited to any combination of two (2) periodic oral  
34 evaluations, comprehensive oral evaluations, or comprehensive  
35 periodontal oral evaluations per year.

36 iii. Must be rendered by a dental professional.

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a. \_\_\_\_\_ b. \_\_\_\_\_

Limited Oral Evaluations – Problem Focused: ~~are~~ available to eAdult Clients presenting with a specific oral health condition or problem

~~b. \_\_\_\_\_~~ sShall be limited to two (2) per year per provider or location.

~~i. \_\_\_\_\_~~

ii. \_\_\_\_\_ Is limited ~~Limited~~ to any combination of two (2) limited problem-focused oral evaluations, detailed and extensive problem-focused oral evaluations, or re-evaluation of limited and problem-focused oral evaluations per year per provider or location.

~~i. \_\_\_\_\_~~ iii. \_\_\_\_\_ If rendered by the same dental provider or the same dental practice, shall be deemed as one of two (2) periodic oral evaluations allowed per year.

~~ii. \_\_\_\_\_~~ Dental hygienists may only provide limited oral evaluations for a client of record. Does not count towards other oral evaluation frequencies.

iv. \_\_\_\_\_ Must be rendered by a dental professional. Dental hygienists shall only provide limited oral evaluations for an Adult Client of record.

v. \_\_\_\_\_ Limited Oral Evaluation – Problem Focused will not be reimbursed if it is provided on the same day as a periodic oral evaluation, a comprehensive oral evaluation, or a comprehensive periodontal evaluation. When both are provided on the same day, only the periodic oral evaluation, the comprehensive oral evaluation, or the comprehensive periodontal evaluation will be reimbursed.

~~iii. \_\_\_\_\_~~ c. \_\_\_\_\_

Comprehensive Oral Evaluation, New or Established Patient~~new clients only,~~

i. \_\_\_\_\_ sShall be limited to one (1) every three (3) years per provider or location.

ii. \_\_\_\_\_ Is limited ~~Limited~~ to any combination of two (2) periodic oral evaluations, comprehensive oral evaluations, or comprehensive periodontal oral evaluations per year.

iii. \_\_\_\_\_ Must be rendered by a ~~dentist~~ dental professional only.

d. \_\_\_\_\_ Detailed and Extensive Oral Evaluation – Problem Focused, By Report:

1 i. Shall be limited to two (2) per year per provider or  
2 location.

3 ii. Is limited Limited to any combination of two (2) limited  
4 problem-focused oral evaluations, detailed and extensive  
5 problem-focused oral evaluations, or re-evaluation of limited and  
6 problem-focused oral evaluations per year.

7 iii. Does not count towards other oral evaluation  
8 frequencies.

9 iv. Must be rendered by a dental professional.

10 v. Detailed and Extensive Oral Evaluation – Problem  
11 Focused, By Report wWill not be reimbursed if it is provided on  
12 the same day as a periodic oral evaluation, a comprehensive  
13 oral evaluation, or a comprehensive periodontal evaluation.  
14 When both are provided on the same day, only the periodic oral  
15 evaluation, the comprehensive oral evaluation, or the  
16 comprehensive periodontal evaluation will be reimbursed.

17 e. Re-evaluation – Limited, Problem Focused (Established Patient; Not  
18 Post-Operative Visit)

19 i. Shall be limited to two (2) per year per provider or  
20 location.

21 ii. Is limited Limited to any combination of two (2) limited  
22 problem-focused oral evaluations, detailed and extensive  
23 problem-focused oral evaluations, or re-evaluation of limited and  
24 problem-focused oral evaluations per year.

25 iii. Does not count towards other oral evaluation  
26 frequencies.

27 iv. Must be rendered by a dental professional.

28 v. Re-evaluation – Limited, Problem Focused (Established  
29 Patient; Not Post-Operative Visit) wWill not be reimbursed if it is  
30 provided on the same day as a periodic oral evaluation, a  
31 comprehensive oral evaluation, or a comprehensive periodontal  
32 evaluation. When both are provided on the same day, only the  
33 periodic oral evaluation, the comprehensive oral evaluation, or  
34 the comprehensive periodontal evaluation will be reimbursed.

35 e. f.

36 Comprehensive Periodontal Oral Evaluation

37 i. Shall be limited to one (1) every three (3) years.

38 ii. Is limited Limited to any combination of two (2) periodic  
39 oral evaluations, comprehensive oral evaluations, or  
40 comprehensive periodontal oral evaluations per year.

iii. Must be rendered by a dental professional.

2. ~~2.~~ Covered Diagnostic Imaging Procedures:

- a. ~~Intra-oral - C;-complete Sseries of Rradiographic Images, shall be limited to one (1) per five (5) years; minimum of ten (10) (periapical or posterior bitewing) films/images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone required in the radiographic survey.-C counts as one (1) set of bitewings per year.~~  
Intra-oral - C;-complete Sseries of Rradiographic Images, shall be limited to one (1) per five (5) years; minimum of ten (10) (periapical or posterior bitewing) films/images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone required in the radiographic survey.-C counts as one (1) set of bitewings per year.
- b. ~~Intra-oral - Periapical fFirst-~~periapical x-ray~~ Radiographic Image, shall be limited to sixsixone (646) per fiveone (51) years. -Intra-oral first periapical x-ray will not be reimbursed if it is provided on the same day as an intra-oral - complete seriesfull mouth series. Where both are provided on the same day, only the intra-oral - complete series full mouth series will be reimbursed.Providers may not bill the same day as full mouth series.~~  
Intra-oral - Periapical fFirst-~~periapical x-ray~~ Radiographic Image, shall be limited to sixsixone (646) per fiveone (51) years. -Intra-oral first periapical x-ray will not be reimbursed if it is provided on the same day as an intra-oral - complete seriesfull mouth series. Where both are provided on the same day, only the intra-oral - complete series full mouth series will be reimbursed.Providers may not bill the same day as full mouth series.
- c. ~~Intra-oral - Periapical Each Aadditional Radiographic Image-~~periapical x-ray~~. Each additional periapical x-ray will not be reimbursed if it is provided on the same day as an intra-oral - complete seriesfull mouth series. Where both are provided on the same day, only the intra-oral - complete series full mouth series will be reimbursed. Providers may not bill the same day as a full mouth series.~~  
Intra-oral - Periapical Each Aadditional Radiographic Image-~~periapical x-ray~~. Each additional periapical x-ray will not be reimbursed if it is provided on the same day as an intra-oral - complete seriesfull mouth series. Where both are provided on the same day, only the intra-oral - complete series full mouth series will be reimbursed. Providers may not bill the same day as a full mouth series.  
Working and final treatment films for endodontics are not covered.
- d. ~~Bitewing - S;-single Radiographic iImage, shall be limited to one (1) set per year; one (1) set is equal to onetwo (21) to four (4) films.~~  
Bitewing - S;-single Radiographic iImage, shall be limited to one (1) set per year; one (1) set is equal to onetwo (21) to four (4) films.
- e. ~~Bitewing;-t - Two Radiographic iImages, shall be limited to one (1) set per year; one (1) set is equal to two (2) to four (4) films.~~  
Bitewing;-t - Two Radiographic iImages, shall be limited to one (1) set per year; one (1) set is equal to two (2) to four (4) films.
- f. ~~Bitewing - Three Radiographic ImagesBitewing; three images;, shall be limited to one (1) set per year; one (1) set is equal to two (2) to four (4) films.~~  
Bitewing - Three Radiographic ImagesBitewing; three images;, shall be limited to one (1) set per year; one (1) set is equal to two (2) to four (4) films.
- g. ~~Bitewing - Four Radiographic ImagesBitewing; four images, shall be limited to one (1) set per year; one (1) set is equal to two (2) to four (4) films.~~  
Bitewing - Four Radiographic ImagesBitewing; four images, shall be limited to one (1) set per year; one (1) set is equal to two (2) to four (4) films.
- h. ~~Vertical Bbitewings - S;- seven (7) to eEight (8) Radiographic iImages, shall be limited to as-one (1) every five (5) years per provider or location. Counts as an intra-oral - complete seriesfull mouth series.~~  
Vertical Bbitewings - S;- seven (7) to eEight (8) Radiographic iImages, shall be limited to as-one (1) every five (5) years per provider or location. Counts as an intra-oral - complete seriesfull mouth series.
- i. ~~Panoramic Radiographic iImage; with or without bitewing, shall be limited to one (1) per five (5) years per provider or location. Counts as an intra-oral - complete seriesfull mouth series.~~  
Panoramic Radiographic iImage; with or without bitewing, shall be limited to one (1) per five (5) years per provider or location. Counts as an intra-oral - complete seriesfull mouth series.

3. Covered Preventive Services

~~Clients determined to fit into a high-risk category, as described below, are eligible for any combination of the following periodontal maintenance and cleanings, but are limited to a maximum of four (4) per year:~~

1 a. Prophylaxis~~Cleaning, (cleaning)~~ shall be limited to two (2) per year. ~~unless client~~  
2 ~~falls into a high risk category.~~ Tooth brushing alone does not qualify as a  
3 prophylaxis.

4 i. Adult Clients who indicate as a~~at~~ high risk ~~for~~of periodontal disease or high  
5 risk of~~for~~ caries may receive any combination of up to a total of four (4)  
6 prophylaxes- (cleanings) or four (4) periodontal maintenance visits per  
7 year. ~~Indicators of high risk of periodontal disease include-is indicated~~  
8 by:

- 9 1. Demonstrable caries ~~Active and untreated caries (decay)~~ at the  
10 time of examination; ~~or~~
- 11 2. H~~h~~istory of periodontal scaling and root planing; ~~or~~
- 12 3. H~~h~~istory of periodontal surgery; ~~or~~
- 13 4. D~~d~~iabetic diagnosis; or
- 14 5. P~~p~~regnancy.

15 b. Topical Application of Fluoride ~~v~~arnish, shall be limited to two (2) per year,  
16 limited to~~for~~ Adult Clients with:

- 17 i. History of dry mouth; ~~and/or~~
- 18 ii. H~~h~~istory of head or neck radiation; or
- 19 ~~iii.~~ iii. Indication of high~~caries~~ risk for caries as that term is defined at  
20 Section 8.201.1. High risk is indicated by active and untreated caries  
21 (decay) at the time of examination. If, at the end of the year the Adult  
22 Client no longer has ~~ve active decay demonstrable caries,~~ he or she ~~they~~  
23 are~~is~~ no longer considered high risk.

24 iv. Limited to any combination of two (2) topical application of fluoride  
25 varnish or topical application of fluoride~~applications~~ per year.

26  
27 c. Topical Application of F~~l~~uoride, shall be limited to two (2) per year, limited to~~for~~  
28 Adult~~e~~ Clients with:

- 29 i. History of dry mouth; ~~and/or~~
- 30 ii. H~~h~~istory of head or neck radiation; or
- 31 iii. Indication of high risk for caries as that term is defined at Section  
32 8.201.1. If, at the end of the year the Adult Client no longer has  
33 demonstrable caries~~active decay,~~ he or she is no longer considered high  
34 risk.
- 35 iv. Limited to any combination of two (2) fluoride varnish or topical fluoride  
36 applications per year. high caries risk. High risk is indicated by active and

1 untreated caries (decay) at the time of examination. If, at the end of the  
 2 year they no longer have active decay, they are no longer considered  
 3 high risk.

4 Covered Minor Restorative Services.

- 5 a. Routine amalgam and composite fillings on posterior and anterior teeth are  
 6 covered services.
- 7 b. Amalgam and composite fillings shall be limited to one (1) time per surface per  
 8 tooth, every three (3) years. The limitation shall begin on the date of service and  
 9 multi-surface fillings are allowable. Amalgam and composite fillings will not be  
 10 reimbursed if it is provided on the same day of treatment as a crown on the same  
 11 tooth. Where both are provided on the same day, only the crown will be  
 12 reimbursed. The occlusal surface is exempt from the three (3) year frequency  
 13 limitations listed below when a multi-surface restoration is required or following  
 14 endodontic therapy.
- 15 cb. Amalgam and composite fillings shall be limited to one (1) time per surface per  
 16 tooth, every three (3) years. The limitation shall begin on the date of service and  
 17 multi-surface fillings are allowable. Amalgam and composite fillings will not be  
 18 reimbursed if it is provided on the same day of treatment as a crown. Where both  
 19 are provided on the same day, only the crown will be reimbursed. The occlusal  
 20 surface is exempt from the three (3) year frequency limitations listed under  
 21 Section 8.201.2.A.4.b. when a multi-surface restoration is required or following  
 22 endodontic therapy.
- 23 d. Prefabricated Stainless Steel Crown, Permanent Tooth; may be replaced once  
 24 every three (3) years.
- 25 e. Prefabricated Stainless Steel Crown, with Resin Window; may be replaced once  
 26 every three (3) years.
- 27 f. Protective Restoration, shall be limited to once per lifetime per tooth, primary and  
 28 permanent teeth.

29 Covered Major Restorative Services

- 30 a. The following crowns are covered:
- 31 i. Single crowns, shall be limited to one (1) per tooth every seven (7) years.
- 32 ii. Core build-up; building, shall be limited to one (1) per tooth every seven  
 33 (7) years.
- 34 iii. Pre-fabricated post and core, shall be limited to one (1) per tooth every  
 35 seven (7) years.
- 36 b. Crowns are covered services only when all of the following conditions are met:
- 37 i. The tooth is in occlusion; and
- 38 ii. The cause of the problem is either decay or fracture; and

- 1                   iii.     The tooth is not a third molar; and
- 2                   iv.     The tooth is not a second molar, unless crowning the second molar is
- 3                             necessary to support a partial denture or to maintain eight (8) artificial or
- 4                             natural posterior teeth in occlusion; and
- 5                   v.     The Adult Client's record reflects evidence of good and consistent oral
- 6                             hygiene; and
- 7                   ~~vi.     Either, One~~ of the following is also true:
  - 8                             1.     The tooth in question requires a multi-surface restoration and it
  - 9                                     cannot be restored with other restorative materials; or
  - 10                            2.     A crown is requested by the dental professional for cracked tooth
  - 11                                     syndrome and the tooth is symptomatic and appropriate testing
  - 12                                     and documentation is provided.
- 13                   c.     Crown materials are limited to porcelain, full porcelain, and noble metal, or high
- 14                             noble metal on anterior teeth and premolars.
- 15                   6.     Covered — Endodontic Services
  - 16                    a.     The following endodontic procedures are covered:
    - 17                            i.     Pulpal debridement, shall be limited to one (1) per tooth per lifetime,
    - 18                                     permanent teeth only.
      - 19                                     1.     Covered in emergency situations only.
      - 20                                     2.     Exempt from prior authorization process but may be
      - 21                                     subject to post-treatment and pre-payment review.
      - 22                                     3.     Will not be reimbursed when root canal is completed on the
      - 23                                     same day by the same dentist or dental office/dental provider or
      - 24                                     location.
    - 25                            ii.    Root Canal, Anterior, anterior Tooth, shall be limited to one (1) per
    - 26                                     tooth per lifetime, permanent teeth only.
    - 27                            iii.   Root Canal, premolar, Bicuspid Tooth, shall be limited to one (1) per
    - 28                                     tooth per lifetime, permanent teeth only.
    - 29                            iv.   Root canal, Molar Tooth, shall be limited to one (1) per tooth per
    - 30                                     lifetime, permanent teeth only.
    - 31                            ~~iv.    Pulpal debridement, one (1) per tooth per lifetime:~~
      - 32                                     ~~1.    Covered in emergency situations only;~~
      - 33                                     ~~2.    Is exempt from prior authorization process but may be subject to post-~~
      - 34                                     ~~treatment and pre-payment review.~~

- 1 v. ~~Retreatment of Pprevious rRoot Ccanal Ttherapy; Aanterior Ttooth;~~  
 2 ~~shall be limited to one (1) per lifetime; permanent teeth only. Will not be~~  
 3 ~~reimbursed only if the original treatment was previously reimbursed to the~~  
 4 ~~same dental provider or location dentist or group not paid by Colorado~~  
 5 ~~Medicaid. Requires prior authorization.~~
- 6 vi. ~~Retreatment of Pprevious rRoot Ccanal Ttherapy; Bicuspid premolar~~  
 7 ~~tTooth; shall be limited to one (1) per lifetime; permanent teeth only. Will~~  
 8 ~~not be reimbursed only if the original treatment was previously~~  
 9 ~~reimbursed to the same dental provider or location dentist or group not~~  
 10 ~~paid by Colorado Medicaid. Requires prior authorization.~~
- 11 vii. ~~Retreatment of Pprevious rRoot eCanal tTherapy; mMolar tTooth; shall~~  
 12 ~~be limited to one (1) per lifetime; permanent teeth only. Will not be~~  
 13 ~~reimbursed only if the original treatment was previously reimbursed to~~  
 14 ~~the same dental provider or location dentist or group not paid by Colorado~~  
 15 ~~Medicaid. Requires prior authorization.~~
- 16 b. Endodontic procedures are covered services when:
  - 17 i. ~~The tooth is not a third molar; and~~
  - 18 ii. ~~The tooth is not a second molar; root canal treatment on second molars~~  
 19 ~~is covered only when the second molar is necessary to support a partial~~  
 20 ~~denture or to maintain eight (8) artificial or natural posterior teeth in~~  
 21 ~~occlusion; and~~
  - 22 iii. ~~The Adult Client's record reflects evidence of good and consistent oral~~  
 23 ~~hygiene; and~~
    - 24 1. ~~The cause of the problem is either decay or fracture; and one of~~  
 25 ~~the following is also true:~~
      - 26 a. ~~The tooth is in occlusion; or~~
      - 27 b. ~~A root canal is requested by the dental professional for~~  
 28 ~~cracked tooth syndrome and the tooth is symptomatic~~  
 29 ~~and appropriate testing and documentation is provided.~~
  - 30 i. ~~The tooth is not a second or third molar. Root canals for third molars are~~  
 31 ~~not covered; root canals for second molars are covered only when the~~  
 32 ~~second molar is essential to keep eight posterior teeth or more in~~  
 33 ~~occlusions or when it is necessary to support a partial denture;~~
  - 34 ii. ~~The tooth is in occlusion;~~
  - 35 iii. ~~A root canal is requested for cracked tooth syndrome and the tooth is~~  
 36 ~~symptomatic and appropriate testing and documentation is provided;~~
  - 37 iv. ~~The client's record reflects evidence of good and consistent oral hygiene;~~  
 38 ~~and~~
  - 39 v. ~~the cause of the problem is either decay or fracture.~~

1 ~~e.~~ c. In all instances in which the Adult Client is in acute pain or there exist  
 2 acute trauma, the dentist should take the necessary steps to relieve the pain and  
 3 complete the ~~necessary e~~ emergency Servicetreatment. In these instances,  
 4 there may not be time for prior authorization. Such emergency  
 5 ~~servicesprocedures may shall~~ be subject to post-treatment and pre-payment  
 6 review.

7 d. Working films (including the final treatment film) for endodontic procedures are  
 8 considered part of the procedure and will not be paid for separately.

9 7. Covered Periodontal Treatment

10 a. Gingivectomy or Gingivoplasty, Four or More Contiguous Teeth or Tooth  
 11 Bounded Spaces per Quadrant; shall be limited to one (1) per three (3) years per  
 12 Adult Client per quadrant. Includes six (6) months of postoperative care.

13 b. Gingivectomy or gingivoplasty, One to Three Contiguous Teeth or Tooth  
 14 Bounded Spaces per Quadrant; shall be limited to one (1) per three (3) years per  
 15 Adult Client per quadrant. Includes six (6) months of postoperative care.

16 c. Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure, per  
 17 Tooth; shall be limited to one (1) per three (3) years per Adult Client per  
 18 quadrant.

19 d. Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis;  
 20 shall be limited to one (1) per three (3) years per Adult Client.

21 i. Full mouth debridement will not be reimbursed if Adult Client's patient  
 22 record demonstrates that the Adult Client has had a prophylaxis  
 23 (cleaning) or periodontal maintenance in the previous twelve (12) month  
 24 period.

25 ii. Other periodontal treatments will not be reimbursed when provided on  
 26 the same date as full mouth debridement. Where other periodontal  
 27 services are provided on the same day, only the full mouth debridement  
 28 will be reimbursed.

29 iii. Prophylaxis (cleaning) will not be reimbursed if it is provided on the same  
 30 day as full mouth debridement. Where both are provided on the same  
 31 day, only the full mouth debridement will be reimbursed.

32 ea. Periodontal Sscaling and rRoot pPlaning; fFour (4) or Mmore tTeeth per  
 33 qQuadrant; shall be limited to one (1)ee per quadrant every three (3) years.  
 34 Requires prior authorization.

35 i. Only covered by report. Periodontal disease must be documented in the  
 36 patient record.

37 ii. Prophylaxis (cleaning) will not be reimbursed if it is provided on the same  
 38 day as a periodontal scaling and root planing; four (4) or more teeth per  
 39 quadrant. Where both are provided on the same day, only the  
 40 periodontal scaling and root planing; four (4) or more teeth per quadrant  
 41 will be reimbursed. Prophylaxis shall not be billed on the same day.

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- iii. No more than two (2) quadrants per day.
- fb. Periodontal ~~Scaling and Root Planning~~, ~~One (1) to Three (3) Teeth per Quadrant~~, shall be limited to one (1) per quadrant every three (3) years. Requires prior authorization.
  - i. Only covered by report. Periodontal disease must be documented in the patient record.
  - ii. Prophylaxis (cleaning) will not be reimbursed if it is provided on the same day as a periodontal scaling and root planing; one (1) to three (3) teeth per quadrant. Where both are provided on the same day, only the periodontal scaling and root planing; one (1) to three (3) teeth per quadrant will be reimbursed.

~~Prophylaxis shall not be billed on the same day.~~
  - iii. No more than two (2) quadrants per day.
- gc. Periodontal ~~Maintenance~~, shall be limited to two (2) times per year; counts as a prophylaxis (cleaning).
  - i. Adult Clients who indicate as high risk of periodontal disease or high risk of caries may receive any combination of up to a total of four (4) prophylaxes (cleanings) or four (4) periodontal maintenance visits per year. Indicators of high risk of periodontal disease include:
    1. Demonstrable caries Active and untreated caries (decay) at the time of examination; or
    2. History of periodontal scaling and root planing; or
    3. History of periodontal surgery; or
    4. Diabetic diagnosis; or
    5. Pregnancy.

~~Can only be approved when history of periodontal disease as evidenced by a history of scaling and root planning and/or osseous surgery.~~
  - ii. ~~Clients with diabetes and pregnant women with histories of periodontal disease are entitled to four (4) per year.~~
- d. ~~Clients who are determined to fit into the high risk category, are eligible for any combination of periodontal maintenance and cleanings, up to four (4) per year.~~

In all instances in which the Adult Client is in acute pain or there exist acute trauma, the dentist should take the necessary steps to relieve the pain and complete the Emergency Services. In these instances, there may not be time for

1 prior authorization. Such emergency services shall be subject to post-treatment  
 2 and pre-payment review.

3 8. Covered Removable Prosthetics

4 a. Removable prosthetics are not covered if eight (8) or more posterior teeth  
 5 (natural or artificial) are in occlusion. Anterior teeth shall be~~are~~ covered,  
 6 irrespective of the number of teeth in occlusion.

7 b. Removable prosthetics covered include:

8 i. Complete Upper Dentures; shall be limited to one (1) time every seven  
 9 (7) years. Includes initial six (6) months of relines. Requires prior  
 10 authorization.

11 ii. Complete Lower Dentures; shall be limited to one (1) time every seven  
 12 (7) years. Includes initial six (6) months of relines. Requires prior  
 13 authorization.

14  
 15 iii. a. Removable pPartial uUpper dDenture, rResin bBased; shall be  
 16 limited to one (1) time every seven (7) years. Requires prior  
 17 authorization.

18 biv. Removable Ppartial Llower Ddenture, rResin bBased; shall be  
 19 limited to one (1) time every seven (7) years. Requires prior  
 20 authorization.

21 cv. Removable Ppartial uUpper dDenture, cCast mMetal fFramework; shall  
 22 be limited to one (1) time every seven (7) years. Requires prior authorization.

23 vi.d. Removable Ppartial lLower dDenture, cCast mMetal fFramework; shall  
 24 be limited to one (1) time every seven (7) years. Requires prior  
 25 authorization.

26 vie. Removable pPartial uUpper dDenture; fFlexible bBase; shall be limited  
 27 to one (1) time every seven (7) years. Requires prior authorization.

28 fviii. Removable Ppartial lLower dDenture; fFlexible bBase; shall be limited  
 29 to one (1) time every seven (7) years. Requires prior authorization.

30 g. Complete Upper Dentures; one (1) time every seven (7) years. Includes initial six  
 31 (6) months of relines

32 h. Complete Lower Dentures; one (1) time every seven (7) years. Includes initial six  
 33 (6) months of relines.

34 9. Covered Oral Ssurgery, Ppalliative ttreatment and Aanesthesia

35 a. The following surgical and palliative treatments are covered:

36 i. Simple Eextraction; shall be limited to one (1) time per tooth.

- 1                   ii.       Surgical ~~E~~extraction~~;~~ shall be limited to one (1) time per tooth.
- 2                   iii.       Incision and ~~D~~rainage of Abscess; concurrent with extraction will be  
3                   covered by report when narrative of medical necessity can be  
4                   documented. Will not be reimbursed in same surgical area and on same  
5                   visit as any other definitive treatment codes; except for covered services  
6                   necessary for diagnosis. Such incision and drainage procedures may be  
7                   subject to post-treatment and pre-payment review. ~~as needed~~
- 8                   iv.       Minor surgical procedures to prepare the mouth for removable  
9                   protheses~~;~~ shall be limited to one (1) time per lifetime per quadrant.
- 10
- 11                  v.       Palliative ~~T~~treatment of ~~D~~dental ~~P~~pain~~;~~ will not be reimbursed on same  
12                  visit as any definitive treatment codes; except for radiographs necessary  
13                  for diagnosis. Will not be reimbursed when only other service is writing a  
14                  prescription.
- 15                  ~~1.       Not payable on the same visit as any definitive treatment codes; except~~  
16                  ~~for covered service necessary for diagnosis.~~
- 17                  vi.       Deep ~~S~~edation~~;~~ ~~g~~eneral ~~a~~nesthesia.
- 18                      1.       Only covered for Adult Clients when there is sufficient evidence  
19                      to support medical necessity.
- 20                      2.       Where multiple levels of anesthesia are provided on the same  
21                      day, only the highest level of anesthesia administered will be  
22                      reimbursed.
- 23                  

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24                  vii.       Intravenous Conscious Sedation.
- 25                      1.       Only covered for Adult Clients when there is sufficient evidence  
26                      to support medical necessity.
- 27                      2.       Where multiple levels of anesthesia are provided on the same  
28                      day, only the highest level of anesthesia administered will be  
29                      reimbursed. General anesthesia and/or deep sedation is not  
30                      covered when it is for the preference of the client or the provider  
31                      and there are no other medical considerations.
- 32                  b.       In all instances in which the Adult Client is in acute pain or there exist acute  
33                  trauma, the dentist should take the necessary steps to relieve the pain and  
34                  complete the Emergency Services. In these instances, there may not be time for  
35                  prior authorization. Such emergency services shall be subject to post-treatment  
36                  and pre-payment review. ~~In all instances in which the client is in acute pain, the~~  
37                  ~~dentist should take the necessary steps to relieve the pain and complete the~~  
38                  ~~necessary emergency treatment. In these instances, there may not be time for~~  
39                  ~~prior authorization. Such emergency procedures may be subject to post-~~  
40                  ~~treatment and pre-payment review.~~
- c.       Biopsies are covered only in instances where there is a suspicious lesion.

- d. Removal of third molars is only covered in instances of acute pain and overt symptomatology.

10. Covered Hospital-Based Services

- a. Dental treatment is covered in a hospital or outpatient facility, under deep sedation or general anesthesia, only when there is medical necessity.

- b. Under this Section 10, medical necessity, shall be limited to the following:

- i. Patients with a documented physical, mental or medically compromising condition.

- ii. Patients who have a dental need and for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.

- iii. Patients who are extremely uncooperative, unmanageable, anxious or uncommunicative and who have dental needs deemed sufficiently urgent that care cannot be deferred. Evidence of the attempt to manage in an outpatient setting must be provided; or,

- iv. Patients who have sustained extensive orofacial and dental trauma.

- c. All operating room cases require prior authorization, even if the complete treatment plan is not available.

- d. General anesthesia and sedation are not covered services when the patient is cooperative and requires minimal dental treatment, or when the patient has a concomitant medical condition which would make general anesthesia or sedation unsafe.

**8.201.2.B. Exclusions.**

- 1. The following services/treatments are not a benefit for Adult Clients age 21 years and older under any circumstances:

- a. Cosmetic Procedures.

- ~~b. Inlay and onlay restorations.~~

- ~~b.~~ Crowns in the following categories:

- i. Cosmetic Crowns (i.e., crowns solely for cosmetic purposes);

- ii. Multiple units of crown and bridge;

- iii. To restore vertical dimension;

- iv. When an Adult Client has active and advanced periodontal disease;

- v. When the tooth is not in occlusion; or

- vi. When there is evidence of periapical pathology.

- 1 ~~dc.~~ Implants.
- 2 ~~ed.~~ Screening and assessment.
- 3 ~~ef.~~ Periodontal surgery.
- 4 ~~g.~~ ~~Protective restorations.~~
- 5 ~~h.~~ ~~Full mouth debridement.~~
- 6 ~~if.~~ Graft procedures.
- 7 ~~gj.~~ Endodontic surgery.
- 8 ~~hk.~~ Treatment for temporomandibular joint disorders.
- 9 ~~l.~~ ~~General Biopsies.~~
- 10 ~~mj.~~ Orthodontic treatment.
- 11 ~~nj.~~ Tobacco cessation counseling.
- 12 ~~ok.~~ Oral hygiene instruction.
- 13 ~~lp.~~ Any service that is not listed as covered.

#### 14 8.201.3 PRIOR AUTHORIZATION REQUEST

- 15 1. Emergency Services do not require a prior authorization before services can be  
16 rendered, ~~and shall be subject to pre-payment review.~~
- 17 ~~2. Prior authorizations or benefits shall be denied for reasons of poor dental prognosis, lack  
18 of dental necessity or appropriateness or because the requested services do not meet  
19 the generally accepted standard of dental care.~~
- 20 ~~32.~~ The following services require prior authorization:
- 21 a. ~~Single crowns; core build-ups; post and cores~~
- 22 ~~b.~~ ~~CC~~Complete and ~~p~~Partial dentures.
- 23 ~~be.~~ Scaling and root planing (periodontal maintenance).
- 24 ~~c.~~ Retreatment of root canals.
- 25 d. ~~Root canals; prior authorization is not required for pulpal debridement in  
26 instances of acute pain~~
- 27 ~~e.~~ ~~Non-emergency surgical extractions~~
- 28 ~~f.~~ ~~Minor surgical procedures.~~

29

~~e. Hospital-based services when treatment is required.~~

~~ef. Unspecified procedures, by report.~~

~~g. General anesthesia and deep sedation except in instances of acute pain or medical necessity.~~

**8.201.4. PROVIDER REQUIREMENTS/REIMBURSEMENT**

8.201.4.A. Dental services shall only be provided by a licensed dental professional ~~licensed dentist or dental hygienist~~ who is enrolled with Colorado Medicaid. Providers shall only provide covered services that are within the scope of their practice.

8.201.4.B. The following billing limitations apply:

1. Restorations:

~~a. Tooth preparation, anesthesia, all adhesives, liners and bases, polishing and occlusal adjustments shall be included within the reimbursement rate for restoration. Unbundling of dental restorations for billing purposes is not allowed.~~

~~b. Amalgam and composite restorations shall be reimbursed at the same rate.~~

~~c. Claim payment to a dental provider for one (1) or more restorations for the same tooth shall be limited to a total of four (4) **or more** tooth surfaces.~~

**8.201.5 ELIGIBLE ~~eligible~~ CLIENTS ~~lients~~**

Dental services described in 8.201.2 shall ~~apply~~ be available to Adult Clients age 21 years and older.

**8.201.6 ANNUAL ~~annual~~ LIMITS ~~imits~~**

1. Dental services for Adult Clients age 21 years ~~of age~~ and older ~~are~~ shall be limited to a total of \$1,000 per ~~adult~~ Medicaid Adult Client recipient per state fiscal year. An Adult-e Client may make personal expenditures for any dental services ~~that exceed the beyond~~ the \$1,000 annual limit, ~~and shall be charged the lower of the Medicaid Fee Schedule or submitted charges.~~

2. The complete and partial dentures benefit ~~shall~~ will be subject to prior authorization and ~~shall~~ will not be subject to the \$1,000 annual maximum for dental services for Adult Clients age 21 years and ~~older~~ over. Although the complete and partial dentures benefit is not subject to the \$1,000 annual maximum for the adult dental services, it ~~shall~~ will be subject to a set Medicaid allowable rate.