EXHIBIT G to Agreement
between the COUNTY OF SACRAMENTO,
hereinafter referred to as "COUNTY", and
COUNTY OF EL DORADO,
hereinafter referred to as "CONTRACTOR"

CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

CONTRACTOR agrees to comply with 45 CFR Part 76.100 (Code of Federal Regulations), which provides that federal funds may not be used for any contracted services, if CONTRACTOR is debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency.

I (We) certify to the best of my (our) knowledge and belief, that CONTRACTOR named below and its principals:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency;

2. Have not within a three (3)-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

3. Are not presently indicted or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in paragraph (2) of this certification; and

4. Have not within a three (3)-year period preceding this application/proposal/agreement had one or more public transactions (Federal, State, or local) terminated for cause or default.

5. Shall notify COUNTY within ten (10) days of receipt of notification that CONTRACTOR is subject to any proposed or pending debarment, suspension, indictments or termination of a public transaction.

6. Shall obtain a certification regarding debarment and suspension from all its subcontractors that will be funded through this Agreement.

7. Hereby agree to terminate immediately, any subcontractor's services that will be/are funded through this Agreement, upon discovery that the subcontractor is ineligible or voluntarily excluded from covered transactions by any federal department or agency.

COUNTY OF EL DORADO

ATTEST: Terri Daly, Acting
Clerk of the Board of Supervisors
By Marcie Mackland
DEPUTY

BY: _____ DATE: 8/21/12

ATTACHMENT A
PART A – RYAN WHITE HIV DENTAL PROGRAM
OPERATIONS MANUAL

I. CRITERIA FOR DENTAL SERVICES UNDER THE PART A RYAN WHITE PROGRAM

This document is a compilation of criteria which apply to dental services. It is designated to provide assistance to dentists treating beneficiaries, in determining service authorization and payment. These criteria are designated to ensure that program funds are spent on services that are medically necessary and are in substantial compliance with the Ryan White HIV Dental Program Policy, and generally accepted standards of dental practice. However, these criteria are but guidelines with which to apply professional judgment in assuring that dental services are appropriate, necessary and of high quality. Professional judgment shall be applied in the determination of benefits and/or payment on the basis of these reliable and valid criteria, evaluation, and interpretation of diagnostic material. Providers and County consultants have established these criteria to standardize the exercise of professional judgment. However, it should be pointed out that this listing does not establish a requirement that consultants must authorize services which meet the criteria listed.

II. REASONABLE AND NECESSARY CONCEPT

A. Outpatient dental services which are reasonable and necessary for the diagnosis and treatment of dental disease, injury, or defect are covered.

B. The underlying principle of whether a service is reasonable and necessary is whether or not the requested service or item is in accord with generally accepted standards of dental practice and is indispensable to the oral health of the beneficiary. Treatment shall be granted or reimbursement made only for covered services appropriate to the present adverse condition which has been approved according to program requirements.

III. EMERGENCY DENTAL SERVICES

A. Within the scope of dental care benefits under the program, emergency dental services may comprise those diverse professional services required in the event of unforeseen medical conditions such as hemorrhage, infection, or trauma. Emergency service shall conform to acceptable standards within our community. Examples of emergency conditions may include, but are not limited to: High risk-to life or minimally disabling conditions, e.g., painful oral-dental infections, pulpal exposures, and fractured teeth.

B. Possible emergency dental treatment may include, but is not limited to: antibiotics administrations; prescriptions of analgesics or antibiotics; temporary or permanent filling; pulpal treatment, where sedative holding measures are not effective; biopsy; denture adjustment; treatment of evulsed teeth; control of post-operative bleeding; treatment for acute periodontitis.

IV. DENTIST PARTICIPATION INFORMATION

The fee payable to providers is at the negotiated rate, as stated in the provider's contracted fee schedule, for covered services, and attached hereto as Attachment B.

V. PRIOR AUTHORIZATION

A. Prior authorization by a County representative may be required for dental services including but not limited to endodontic and periodontic treatment, cast partials, castings, dentures, and referrals to outside dental specialty providers (see covered services for specifics).

B. The cost of hospitalization is not covered. The dental procedures performed during hospitalization will be covered at the same rate specified in the provider's contracted fee schedule. No other hospital related costs are covered.

VI. UNLISTED PROCEDURES (9999)

A. Complete description of the proposed treatment and the need for service must be documented.

B. The fee requested must be listed and is subject to review by County representatives.

C. Non-emergency unlisted procedures require prior authorization.

VII. COVERED PROCEDURES

A. DIAGNOSTIC

PROCEDURE	DESCRIPTION – DIAGNOSTIC
0110	Examination, initial episode of treatment only. Radiographs are covered when taken in compliance with state and federal regulations for radiation hygiene, and when they fully depict subject teeth and associated structures by standard illumination, and are appropriate to the symptoms and conditions of the patient.
0120	Periodic oral examination limited to any two examinations (0110, 0120, 0130) per contract year.
0210	Intraoral, complete series when medically necessary and in accepted standards of dental practice. Limited to once in a three (3) year period.
0230	Intraoral periapical, each additional film (maximum ten films).
0240	Intraoral, occlusal film.
0272	Bitewings, two films. Limited to once per contract year.
0274	Bitewings, four films. Limited to once per contract year.
0330	Panographic-type film, single film. Limited to once every three (3) years.
0470	Diagnostic casts.

B. PREVENTIVE: Covered only when in conjunction with restorative procedures and limited to two (2) times per contract year.

PROCEDURE	DESCRIPTION - PREVENTIVE
1110	Prophylaxis – adult, limited to two (2) times per contract year.
1120	Prophylaxis – child, limited to two (2) times per contract year.
1201	Topical application of fluoride (including prophylaxis) – child.
1203	Topical application of fluoride (prophylaxis not included) – child.
1204	Topical application of fluoride (including prophylaxis) – adult.
1205	Topical application of fluoride (prophylaxis not included) – adult.
1351	Sealant – per tooth, children only.

C. RESTORATIVE DENTISTRY

1. The program provides temporary restoration, amalgam, composite, or plastic restorations for treatment of caries. If the tooth can be restored with such material, any crown or jacket is not covered.
2. Laboratory processed crowns are benefits for permanent anterior teeth and permanent posterior teeth once in a five (5) year period.
3. When a crown is placed on a posterior molar tooth, porcelain, resin and similar materials are optional. An allowance will be made based on the fee for a full metal crown.
4. Authorization may be granted for the lowest cost item or service that meets the patient's medical needs. When acting upon request for approval for laboratory processed crowns, these regulations as well as the overall condition of the mouth, patient's receptivity toward treatment and willingness to comply with maintaining good oral hygiene, oral health status, arch integrity, and prognosis of remaining teeth shall be considered.
5. Laboratory processed crowns may be granted where longevity is essential and a lesser service will not suffice, when extensive coronal destruction is radiographically demonstrated and treatment is beyond intercoronal restoration.
6. Cast or performed posts are covered for devitalized teeth only.
7. Laboratory process crowns on endodontically treated teeth are covered only after satisfactory completion of the root canal therapy.

PROCEDURE	DESCRIPTION - RESTORATIVE DENTISTRY
2110	Amalgam restoration, primary tooth, one surface.
2110	Amalgam restoration, primary tooth, one surface.
2120	Amalgam restoration primary tooth, two surfaces.
2130	Amalgam restoration, primary tooth, three surfaces.
2131	Amalgam restoration, primary tooth, four or more surfaces.
2140	Amalgam restoration, permanent tooth, one surface.
2150	Amalgam restoration, permanent tooth, two surfaces.
2160	Amalgam restoration, permanent tooth, three surfaces.
2161	Amalgam restoration, permanent tooth, four or more surfaces.
2330	Composite restoration, one surface – anterior tooth.
2331	Composite restoration, two surfaces – anterior tooth.
2332	Composite restoration, three surfaces – anterior tooth.
2335	Composite restoration, four or more surfaces or involving incisal angle – anterior.
2750	Crown, porcelain fused to metal (anterior teeth only).
2790	Crown, full case high noble metal.
2910	Re-cement inlay, facing, pontic.
2920	Re-cement crown.
2930	Crown stainless steel, primary.
2931	Crown stainless steel, permanent.
2950	Core buildup, including any pins.
2951	Pin retention (per pin), maximum three pins per tooth.
2952	Cast post and core, in addition to crown.
2954	Prefabricated post and core, in addition to crown.
2970	Temporary crown or stainless steel band.

D. ENDODONTICS – GENERAL POLICIES

1. Includes those procedures when complete root canal filling on permanent teeth:

   a) Root canal therapy is a covered benefit, if medically necessary – tooth is non-vital. The prognosis of the affected tooth and other remaining teeth will be evaluated in considering root canal therapy.

   b) Authorization and payment for root canal treatment includes, but is not limited to, any of the following procedures:

      (1) Any incision and drainage necessary on relation to the root canal therapy.

      (2) Vitality test.

      (3) Radiographs required during treatment.

      (4) Culture.

      (5) Medicated treatment.

      (6) Final filling of canals.

      (7) Final treatment radiographs.

   c) Necessary retreatment and postoperative care within a 90-day period is included in the reimbursement fee for the root canal therapy.

   d) Root canal therapy must be completed prior to payment. Date of service on the claim for payment must reflect the final completion date.

2. Emergency root canal treatment may be done when any of the following conditions exist and documentation substantiates the need:

   a) Failure of a palliative treatment to relieve the acute distress of the patient.

   b) When a tooth has been accidentally evulsed.

   c) When there has been a fracture of the crown of a tooth exposing the pulpal tissue.

3. The prognosis of the affected tooth, other remaining teeth, and the type of restorations allowable will be evaluated in considering requested root canal therapy.

4. Extraction may be suggested for a tooth with a fractured root, external or internal resorption, or one that is easily replaced by addition to an existing removable dental appliance.

PROCEDURE	**DESCRIPTION** - ENDODONTICS
3110	Pulp cap – direct (excluding final restoration).
3120	Pulp cap – indirect (excluding final restoration).
3220	Therapeutic pulpotomy (excluding final restoration).
3310	Anterior root canal therapy (excluding final restoration).
3320	Bicuspid root canal therapy (excluding final restoration).
3330	Molar root canal therapy (excluding final restoration).
3410	Apicoectomy (separate surgical procedure) per tooth: This procedure when there is severe apical curvature, blockage of the canal by calcific deposits, dentinal shavings or pulp chamber debris, and when a canal wall has been perforated or "shelved" during canal enlargement.

E. PERIODONTICS

General Policies: Accepted dental practice indicates that periodontal treatment should use therapeutic measures on an ordered schedule limited to the direct, least invasive measures necessary to achieve the result.

PROCEDURE	**DESCRIPTION** - PERIODONTICS
4210	Gingivectomy or gingivoplasty – per quadrant.
4211	Gingivectomy or gingivoplasty, treatment per tooth (fewer than six teeth): May be authorized when an isolated pocket has not responded to conservative treatment.
4220	Gingival curettage, surgical, per quadrant, by report.
4240	Gingival flap procedure, including root planning – per quadrant.
4341	Subgingival curettage and root planning, per treatment: Root planing includes the removal of calculus deposits on the tooth and root, the smoothing of the root and surface; subgingival curettage – the removal of granulation tissue and pocket lining epithelium. Treatment is limited to those areas requiring immediate attention.
4910	Periodontal maintenance procedures (following active therapy).

F. PROSTHETICS - REMOVABLE

1. Full dentures are covered when medically necessary using standard procedures which exclude precision attachments, implants or other specialized techniques. These services are covered only once in a five year period

   a) Prevent a significant disability.

   b) Replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control.

2. Request for the extraction of all remaining teeth in preparation for complete immediate dentures and the immediate full dentures following full mouth extractions (both anterior and posterior) is a covered benefit.

3. Construction of new dentures shall not be authorized if conditions including but not limited to the following exist:
   a) It would be impossible or highly improbable for a beneficiary to adjust to a new prosthetic appliance. This is particularly applicable in those cases where the patient has been without dentures for an extended period of time or where the beneficiary may exhibit a poor adaptability due to psychological and/or motor deficiencies.
   b) The dental history shows that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable (psychological).
   c) Repair, relining, or reconstruction of the recipient's present denture will make it serviceable.
   d) The denture, in the patient's opinion only, is loose or ill-fitting but is recently enough constructed to indicate deficiencies limited to those inherent in all dentures.
   e) Where the request for the denture(s) is primarily cosmetic, the authorization shall be denied.
   f) The patient has been without dentures for at least five (5) years and is currently functioning without dentures.
4. Immediate dentures may be authorized when conditions including but not limited to the following exist:
   a) Extensive or rampant caries are exhibited.
   b) Severe periodontal involvement is indicated.
      (1) When the clinical exam shows excessive mobility and severe gingivitis.
      (2) When tooth mobility is not grossly evident and when the gingival tissues are not severely involved, consideration should be given to a more conservative treatment and denture request denied.
   c) Numerous teeth are missing and masticating ability has been diminished.
      (1) Where there is not capability of any posterior occlusion with existing dentition.
      (2) When a functional, although minimal, occlusion exists, the urgent need for prosthesis should be carefully evaluated.
5. Requests for replacement dentures shall include adequate supportive documentation and shall be preauthorized. Replacement dentures may be authorized more often than once in a five (5) year period when:
   a) Catastrophic loss of denture.
   b) Surgical or traumatic loss of oral-facial anatomic structures.
   c) Replacement of existing dentures.
      (1) When there has been a complete deterioration of the denture base or teeth.
      (2) When there has been a complete loss of retentive ability, vertical dimension, or balanced occlusion of existing dentures.
6. Requests for dentures for the long-standing edentulous patient will be denied.
7. A removable Partial denture is covered when necessary for the replacement of anterior teeth only.
8. A covered removable partial denture may be authorized only once in a five (5) year period except to:
   (1) Prevent a significant disability.
   (2) Replace a covered removable dental prosthesis which has been lost or destroyed due to circumstances beyond the beneficiary's control.

PROCEDURE	**DESCRIPTION** - PROSTHETICS - REMOVABLE
5110	Complete denture - maxillary.
5120	Complete denture – mandibular.
5130	Immediate denture – maxillary.
5140	Immediate denture – mandibular.
5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth).
5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth).

5213	Maxillary partial denture – predominantly base metal (including any conventional clasps, rests and teeth).
5214	Mandibular partial denture – predominantly base metal (including any conventional clasps, rests and teeth).
5410	Denture adjustment – maxillary denture.
5411	Denture adjustment – mandibular denture.
5421	Denture adjustment – maxillary partial.
5422	Denture adjustment – mandibular partial.
5510	Repair broken denture base only (complete or partial).
5520	Replace broken denture teeth only.
5610	Repair resin denture base.
5620	Repair cast framework.
5630	Repair or replace clasp.
5640	Replace broken teeth – per tooth
5650	Add tooth to partial denture to replace newly extracted natural tooth.
5660	Add clasp to existing partial denture.
5710	Rebase complete maxillary denture.
5711	Rebase complete mandibular denture.
5720	Rebase maxillary partial denture.
5721	Rebase mandibular partial denture.
5730	Reline complete maxillary denture – chairside.
5731	Reline complete mandibular denture – chairside.
5740	Reline partial maxillary denture – chairside.
5741	Reline partial mandibular denture – chairside.
5750	Reline complete maxillary denture – lab.
5751	Reline complete mandibular denture – lab.
5760	Reline partial maxillary denture – lab.
5761	Reline partial mandibular denture – lab.
5810	Interim complete denture (maxillary).
5811	Interim complete denture (mandibular).
5820	Interim partial denture (maxillary).
5821	Interim partial denture (mandibular).
5850	Tissue conditioning – maxillary.
5851	Tissue conditioning – mandibular.

G. PROSTHETICS - FIXED

PROCEDURE	**DESCRIPTION** - PROSTHETICS - FIXED
6210	Pontic-cast with high noble metal.
6240	Pontic-porcelain with high noble metal.
6250	Pontic-resin with high noble metal.
6750	Bridge crown-porcelain with high noble metal.
6790	Bridge crown-full case with high noble metal.
6930	Re-cement bridge.

6940	Stress breaker.
6970	Cast post and core in addition to bridge crown (endodontically treated tooth).
6971	Cast post as part of bridge crown.
6972	Prefabricated post and core in addition to bridge crown (endodontically treated tooth).
6980	Repair fixed bridge.
6999	Unspecified fixed prosthodontic procedure, by report.

H. ORAL SURGERY

EXTRACTIONS – GENERAL POLICIES

1. Diagnostic x-rays fully depicting subject tooth (teeth) are usually required for all intraoral surgical procedures. (See specific procedure code for details)
2. The extraction of asymptomatic teeth is not a benefit.
3. The following instances may be justified as being symptomatic:
   a) Teeth which are involved with a cyst, tumor, or neoplasm.
   b) The extraction of all remaining teeth in preparation for a full prosthesis.
   c) A malaligned tooth that causes intermittent gingival inflammation.
   d) Perceptible radiologic pathology that fails to elicit symptoms.
4. By repot procedures may be used when the provider has encountered unforeseen complications which are not usually considered normal to the particular procedure listed.

PROCEDURE	**DESCRIPTION** – ORAL SURGERY
7110	Removal of erupted tooth, uncomplicated, first tooth
7120	Removal of erupted tooth (teeth), uncomplicated, each additional tooth.
7130	Removal of root or root tip.
7210	Removal of erupted tooth, surgical.
7220	Removal of impacted tooth – soft tissue: Removal of any permanent tooth by the open method which may or may not include removal of bone in those cases where the major portion of all of the crown of the tooth was covered by mucogingival tissue and not alveolar bone.
7230	Removal of impacted tooth – partially bony.
7240	Removal of impacted tooth – totally bony: Removal of any tooth by the open method where it is necessary to expose any portion of the crown of the tooth by removal of alveolar bone.
7250	Surgical removal of residual tooth roots (cutting procedure).
7285	Biopsy and pathology reports of oral tissue – hard: Refer to oral surgeon.
7286	Biopsy and pathology reports of oral tissue – soft: Refer to oral surgeon.
7310	Alveolectomy (Alveoloplasty): Is a collective term for the operation by which the shape and condition of the alveolar process is improved for preservation of the residual bone.
7430	Excision of benign tumor – lesion diameter up to 1.25 cm.
7431	Excision of benign tumor – lesion diameter greater than 1.25 cm.
7440	Excision of malignant tumor – lesion diameter up to 1.25 cm.
7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm.
7465	Destruction of lesion(s) by physical or chemical methods, by report.
7510	Incision and drainage of abscess, intraoral soft tissue.
7520	Incision and drainage of abscess, extraoral soft tissue.
7550	Sequestrectomy for osteomyelitis or bone abscess, superficial.

7970	Excision of hyperplastic tissue, per arch: A benefit when inflammatory hyperplastic tissue interferes with normal use of function of a prosthetic appliance.
7971	Excision pericoronal gingiva, operculectomy.

I. ADJUNCTIVE GENERAL SERVICES

1. Must be pre-authorized. Claim must be accompanied by documentation from primary care physician as to the medical necessity.
2. General anesthesia as used for dental pain control means the elimination of all sensation accompanied by a state of unconsciousness.
3. Office (outpatient) general anesthesia may be payable when the provider indicates local anesthesia is contraindicated.

PROCEDURE	**DESCRIPTION** – ADJUNCTIVE GENERAL SERVICES
9110	Emergency treatment, palliative, per visit.
9220	General anesthesia – first thirty (30) minutes.
9221	General anesthesia – each additional 15 minutes.
9430	Office visit during regular office hours for treatment and/or observation of teeth and supporting structures.
9440	Professional visit after regular office hours or to bedside.
9930	Post-operative visit, complications (post surgical e.g., osteitis).
9940	Occlusal guard, by report.
9951	Occlusal adjustment – limited.
9952	Occlusal adjustment – complete.

J. UNLISTED PROCEDURES

PROCEDURE	**DESCRIPTION** – UNLISTED PROCEDURES
9999	Unlisted procedures; requires definition and requires prior authorization by County for non-emergency procedures.

VIII. NOT COVERED PROCEDURES

The following are not benefits under the program:

A. DIAGNOSTIC and PREVENTIVE

Preventive control program, including fissure sealant, prophylactic fillings, oral hygiene instruction, dietary instruction and prophylaxis when not in conjunction with restorative treatment. (Prophy's can be obtained at Sacramento City College Dental Hygiene Department).

B. ORAL SURGERY

1. Experimental procedures.
2. Asymptomatic extractions.
3. Surgical correction of the maxilla and mandible by grafts for denture retention.
4. Surgical treatment of temporomandibular joint disturbances.
5. Surgical treatment of prognathism or retrognathism.
6. Surgical treatment to correct congenital or developmental malformation.

C. PRESCRIBED DRUGS – Reimbursement for prescription drugs is not covered unless there is no other payor source and is limited to only those drugs that are currently prescribed by the dental community for dental related needs.

D. ORTHODONTIC SERVICES

E. RESTORATIVE DENTISTRY

1. Full mouth reconstruction procedure.
2. Cosmetic procedure and restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusion. These include:
   a) Increasing vertical dimension.
   b) Replacing or stabilizing tooth structure loss by attrition.
   c) Realignment of teeth.
   d) Periodontal splinting.
   e) Gnathologic recordings.
   f) Equilibration.
   g) Surgical treatment of disturbances of temporomandibular joint.
   h) Services for the surgical treatment of prognathism or retrognathism.
   i) Treatment of incipient or non-active caries as demonstrated radiographically.

F. PROSTHETICS

1. The program provides for replacement of missing teeth with full dentures or partials using standard procedures, when "medically necessary" by the dentist. A service is "medically necessary" or is a "medical necessity" when it is reasonable to protect life, to prevent significant illness or significant disability, or to alleviate sever pain.
2. Medically necessary dentures or partials must be preauthorized and are limited to once in a five (5) year period, unless rendered totally unfunctionable and not repairable.
3. Treatment involving the following is not covered:
   a) Specialized techniques
   b) Precious metal for removable appliances
   c) Overlays, implants and associated appliances
   d) Personalization or characterization

COUNTY OF SACRAMENTO	COST REIMBURSEMENT AGREEMENT NO. 7207500-13/15-709		
ATTACHMENT B			
Sacramento TGA Oral Health Care Fee Schedule			
Rate = $115 Per Unit of Service			
CODE	DESCRIPTION	Units of Service	FEE
00110	Initial oral examination	0.4	$46.00
00120	Periodic oral examination	0.3	$34.50
00210	Intraoral-complete series (including bitewings)	0.7	$80.50
00220	Intraoral-periapical-first film	0.2	$23.00
00230	Intraoral-periapical-each additional film	0.1	$11.50
00240	Intraoral-occlusal film	0.3	$34.50
00270	Bitewing-single film	0.2	$23.00
00272	Bitewing-two films	0.3	$34.50
00274	Bitewing-four films	0.4	$46.00
00330	Panoramic film	0.6	$69.00
00470	Diagnostic casts	0.6	$69.00
01110	Prophylaxis-adult	0.6	$69.00
01120	Prophylaxis-child	0.5	$57.50
01201	Topical application of fluoride (including prophylaxis)-child	0.6	$69.00
01203	Topical application of fluoride (prophylaxis not included)-child	0.2	$23.00
01204	Topical application of fluoride (prophylaxis not included)-adult	0.3	$34.50
01205	Topical application of fluoride (including prophylaxis)-adult	0.7	$80.50
01351	Sealant-per tooth	0.3	$34.50
02110	Amalgam-one surface, primary	0.6	$69.00
02120	Amalgam-two surfaces, primary	0.7	$80.50
02130	Amalgam-three surfaces, primary	0.9	$103.50
02131	Amalgam-four or more surfaces, primary	1.0	$115.00
02140	Amalgam-one surface, permanent	0.7	$80.50
02150	Amalgam-two surfaces, permanent	0.9	$103.50
02160	Amalgam-three surfaces, permanent	1.0	$115.00
02161	Amalgam-four or more surfaces, permanent	1.2	$138.00
02330	Resin-one surface, anterior	0.9	$103.50
02331	Resin-two surfaces, anterior	1.0	$115.00
02332	Resin-three surfaces, anterior	1.2	$138.00
02335	Resin-four or more surfaces or involving incisal angle (anterior)	1.7	$195.50
02750	Crown-porcelain fused to high noble metal	7.8	$897.00
02751	Crown-porcelain fused to predominantly base metal	6.7	$770.50
02752	Crown-porcelain fused to noble metal	7.1	$816.50
02790	Crown-full cast high noble metal	7.0	$805.00
02791	Crown-full cast predominantly base metal	6.1	$701.50

ATTACHMENT B			
Sacramento TGA Oral Health Care Fee Schedule			
Rate = $115 Per Unit of Service			
CODE	DESCRIPTION	Units of Service	FEE
02792	Crown-full cast noble metal	7.0	$805.00
02910	Recement inlay	0.8	$92.00
02920	Recement crown	0.8	$92.00
02930	Prefabricated stainless steel crown - primary tooth	1.8	$207.00
02931	Prefabricated stainless steel crown - permanent tooth	2.1	$241.50
02950	Core buildup, including any pins	1.3	$149.50
02951	Pin retention-per tooth, in addition to restoration	0.4	$46.00
02952	Cast post and core in addition to crown	2.1	$241.50
02954	Prefabricated post and core in addition to crown	1.9	$218.50
02970	Temporary crown (fractured tooth)	1.1	$126.50
02980	Crown repair, by report	2.8	$322.00
03110	Pulp cap-direct (excluding final restoration)	0.4	$46.00
03120	Pulp cap-indirect (excluding final restoration)	0.6	$69.00
03220	Therapeutic pulpotomy (excluding final restoration)	0.8	$92.00
03310	Anterior root canal (excluding final restoration)	4.1	$471.50
03320	Bicuspid root canal (excluding final restoration)	4.4	$506.00
03330	Molar root canal (excluding final restoration)	5.9	$678.50
03410	Apicoectomy/Periradicular surgery- anterior	3.4	$391.00
04210	Gingivectomy or gingivoplasty-per quadrant	3.0	$345.00
04211	Gingivectomy or gingivoplasty-per tooth	0.8	$92.00
04220	Gingival curettage, surgical, per quadrant, by report	1.5	$172.50
04240	Gingival flap procedure, including root planing- per quadrant	3.6	$414.00
04341	Periodontal scaling and root planing per quad	1.4	$161.00
04910	Periodontal maintenance procedure (following active therapy)	0.8	$92.00
05110	Complete denture - maxillary	8.1	$931.50
05120	Complete denture - mandibular	8.1	$931.50
05130	Immediate denture - maxillary	8.4	$966.00
05140	Immediate denture - mandibular	8.4	$966.00
05211	Maxillary partial denture-resin base (including clasps, rests, teeth)	7.1	$816.50
05212	Mandibular partial denture-resin base (including clasps, rests, teeth)	7.1	$816.50
05213	Maxillary partial denture-cast metal framework (including clasps, rests, teeth)	9.2	$1,058.00
05214	Mandibular partial denture - cast metal framework (including clasps, rests, teeth)	9.8	$1,127.00
05410	Adjust complete denture - maxillary	0.5	$57.50
05411	Adjust complete denture - mandibular	0.5	$57.50
05421	Adjust partial denture - maxillary	0.5	$57.50
05422	Adjust partial denture - mandibular	0.5	$57.50
05510	Repair broken complete denture base	1.0	$115.00

ATTACHMENT B			
Sacramento TGA Oral Health Care Fee Schedule			
Rate = $115 Per Unit of Service			
CODE	DESCRIPTION	Units of Service	FEE
05520	Replace missing or broken teeth-complete denture (each tooth)	0.9	$103.50
05610	Repair resin denture base	1.0	$115.00
05620	Repair cast framework	1.5	$172.50
05630	Repair or replace broken clasp	1.5	$172.50
05640	Replace broken teeth-per tooth	0.9	$103.50
05650	Add tooth to existing partial denture	1.4	$161.00
05660	Add clasp to existing partial denture	1.8	$207.00
05710	Rebase complete maxillary denture	3.4	$391.00
05711	Rebase complete mandibular denture	3.4	$391.00
05720	Rebase maxillary partial denture	3.4	$391.00
05721	Rebase mandibular partial denture	3.5	$402.50
05730	Reline complete maxillary denture (chairside)	1.7	$195.50
05731	Reline complete mandibular denture (chairside)	1.7	$195.50
05740	Reline maxillary partial denture (chairside)	1.7	$195.50
05741	Reline mandibular partial denture (chairside)	1.7	$195.50
05750	Reline complete maxillary denture (laboratory)	2.6	$299.00
05751	Reline complete mandibular denture (laboratory)	2.5	$287.50
05760	Reline maxillary partial denture (laboratory)	2.5	$287.50
05761	Reline mandibular partial denture (laboratory)	2.5	$287.50
05810	Interim complete denture (maxillary)	4.3	$494.50
05811	Interim complete denture (mandibular)	4.3	$494.50
05820	Interim partial denture (maxillary)	3.7	$425.50
05821	Interim partial denture (mandibular)	3.7	$425.50
05850	Tissue conditioning (maxillary)	1.0	$115.00
05851	Tissue conditioning (mandibular)	1.0	$115.00
06210	Pontic-cast high noble metal	7.0	$805.00
06211	Pontic-cast predominantly base metal	6.1	$701.50
06212	Ponic-cast noble metal	6.7	$770.50
06240	Pontic-porcelain fused to high noble metal	7.9	$908.50
06241	Pontic-porcelain fused to predominantly base metal	6.7	$770.50
06242	Pontic-porcelain fused to noble metal	7.0	$805.00
06750	Crown-porcelain fused to high noble metal	7.9	$908.50
06751	Crown-porcelain fused to predominantly base metal	6.6	$759.00
06752	Crown-porcelain fused to noble metal	7.0	$805.00
06790	Crown-full cast high noble metal	7.1	$816.50
06791	Crown-full cast predominantly base metal	6.3	$724.50
06792	Crown-full cast noble metal	7.0	$805.00

ATTACHMENT B			
Sacramento TGA Oral Health Care Fee Schedule			
Rate = $115 Per Unit of Service			
CODE	DESCRIPTION	Units of Service	FEE
06930	Recement fixed partial denture	1.0	$115.00
06940	Stress breaker	2.6	$299.00
06970	Cast post and core in addition to fixed partial denture retainer	2.9	$333.50
06971	Cast post and core as part of a fixed partial denture retainer	2.9	$333.50
06972	Prefabricated post and core in addition to fixed partial denture retainer	2.3	$264.50
06973	Core build up for retainer, including any pins	1.8	$207.00
06980	Fixed partial denture repair, by report	5.5	$632.50
07110	Single tooth extraction	0.8	$92.00
07120	Each additional tooth extraction	0.8	$92.00
07130	Root removal-exposed roots	1.0	$115.00
07210	Surgical removal of erupted tooth requiring elevation of flap and/or removal of bone	1.3	$149.50
07220	Removal of impacted tooth-soft tissue	1.5	$172.50
07230	Removal of impacted tooth-partial bony	2.0	$230.00
07240	Removal of impacted tooth-complete bony	3.0	$345.00
07250	Surgical removal of residual tooth roots (cutting procedure)	1.4	$161.00
07285	Biopsy of oral tissue-hard	2.0	$230.00
07286	Biopsy of oral tissue-soft	1.5	$172.50
07310	Alveoloplasty in conjunction with extractions-per quadrant	1.3	$149.50
07311	Alveoloplasty not in conjunction with extractions-per quadrant	1.3	$149.50
07430	Excision of benign tumor-lesion diameter up to 1.25 cm	1.4	$161.00
07431	Excision of benign tumor-lesion diameter greater than 1.25 cm	2.0	$230.00
07440	Excision of malignant tumor-lesion diameter up to 1.25 cm	2.9	$333.50
07441	Excision of malignant tumor-lesion diameter greater than 1.25 cm	4.8	$552.00
07465	Destruction of lesion(s) by physical or chemical methods, by report	2.3	$264.50
07510	Incision and drainage of abscess-intraoral soft tissue	0.8	$92.00
07520	Incision and drainage of abscess-extraoral soft tissue	2.1	$241.50
07550	Sequestrectomy for osteomyelitis	2.9	$333.50
07970	Excision of hyperplastic tissue-per arch	2.3	$264.50
07971	Excision of pericoronal gingiva	0.9	$103.50
09110	Palliative (emergency) treatment of dental pain-minor procedure	0.7	$80.50
09430	Office visit for observation (during office hours, no other service performed)	0.4	$46.00
09440	Office visit after regularly scheduled hours	1.0	$115.00
09930	Treatment of complication (post surgical) unusual circumstances, by report	0.4	$46.00
09940	Occlusal guard, by report	3.8	$437.00
09951	Occlusal adjustment-limited	1.0	$115.00
09952	Occlusal adjustment-complete	3.8	$437.00
09999	Unspecified adjunctive procedure, by report		$0.00

County of Sacramento
Department of Health and Human Services
Ryan White Program
CONTRACTOR BUDGET

Contractor: County of El Dorado
Contract Number: 7207500-13/15-709 **Effective Date:** 7/1/2012
Budget Term: July 1, 2012 through June 30, 2015 **Contractor Budget Version#:** 1

Service Type	Service Code	Unit Description	Unit Rate	Undupli-cated Clients	Units of Service	7/1/12 - 2/28/13 TOTAL
Transportation Svcs.	11025	1 vendor paid transportation dollar	$ 1.10	33.00	3,010.00	$ 3,311
Oral Health Care	02002	1 vendor paid dollar for dental visit	$ 1.10	3.00	142.73	$ 157
Mental Health	03045	1 vendor paid adult individual - psychological	$ 1.10	2.00	684.55	$ 753
Emergency Financial Assistance	11029	1 other critical need dollar	$ 1.10	30.00	1,278.18	$ 1,406
Ambulatory Care	01008	1 vendor paid dollar for primary care visit w/HCP	$ 1.10	20.00	665.45	$ 732
	01009	1 vendor paid dollar for speciality care visit w/HCP	$ 1.10	1.00	54.55	$ 60
	01010	1 vendor paid dollar for lab visit	$ 1.10	2.00	239.09	$ 263
Case Management	14020	1 15 min Field-based face-to-face encounter	$ 16.75	35.00	4,391.34	$ 73,555
	14021	1 15-min Field-based other encounter	$ 16.75	35.00	1,463.76	$ 24,518
					7/1/12 - 2/28/13 TOTAL	$ 104,755

Service Type	Service Code	Unit Description	Unit Rate	Undupli-cated Clients	Units of Service	3/1/13 - 2/28/14 BUDGET
Transportation Svcs.	11025	1 vendor paid transportation dollar	$ 1.10	33.00	4,196.36	$ 4,616
Oral Health Care	02002	1 vendor paid dollar for dental visit	$ 1.10	3.00	1,136.36	$ 1,250
Mental Health	03045	1 vendor paid adult individual - psychological	$ 1.10	2.00	1,275.45	$ 1,403
Emergency Financial Assistance	11029	1 other critical need dollar	$ 1.10	30.00	4,545.45	$ 5,000
Ambulatory Care	01008	1 vendor paid dollar for primary care visit w/HCP	$ 1.10	20.00	2,594.55	$ 2,854
	01009	1 vendor paid dollar for speciality care visit w/HCP	$ 1.10	1.00	109.09	$ 120
	01010	1 vendor paid dollar for lab visit	$ 1.10	2.00	478.18	$ 526
Case Management	14020	1 15 min Field-based face-to-face encounter	$ 16.75	35.00	7,269.07	$ 121,757
	14021	1 15-min Field-based other encounter	$ 16.75	35.00	1,194.03	$ 20,000
					3/1/13 - 2/28/14 TOTAL	$ 157,526

Service Type	Service Code	Unit Description	Unit Rate	Undupli-cated Clients	Units of Service	3/1/14 - 2/28/15 BUDGET
Transportation Svcs.	11025	1 vendor paid transportation dollar	$ 1.10	33.00	4,196.36	$ 4,616
Oral Health Care	02002	1 vendor paid dollar for dental visit	$ 1.10	3.00	1,136.36	$ 1,250
Mental Health	03045	1 vendor paid adult individual - psychological	$ 1.10	2.00	1,275.45	$ 1,403
Emergency Financial Assistance	11029	1 other critical need dollar	$ 1.10	30.00	4,545.45	$ 5,000
Ambulatory Care	01008	1 vendor paid dollar for primary care visit w/HCP	$ 1.10	20.00	2,594.55	$ 2,854
	01009	1 vendor paid dollar for speciality care visit w/HCP	$ 1.10	1.00	109.09	$ 120
	01010	1 vendor paid dollar for lab visit	$ 1.10	2.00	478.18	$ 526
Case Management	14020	1 15 min Field-based face-to-face encounter	$ 16.75	35.00	7,269.07	$ 121,757
	14021	1 15-min Field-based other encounter	$ 16.75	35.00	1,194.03	$ 20,000
					3/1/14 - 2/28/15 TOTAL	$ 157,526

Ryan White Program
CONTRACTOR BUDGET

Contractor: County of El Dorado
Contract Number: 7207500-13/15-709 **Effective Date:** 7/1/2012
Budget Term: July 1, 2012 through June 30, 2015 **Contractor Budget Version#:** 1

Service Type	Service Code	Unit Description	Unit Rate	Undupli-cated Clients	Units of Service	3/1/15 - 6/30/15 BUDGET
Transportation Svcs.	11025	1 vendor paid transportation dollar	$ 1.10	33.00	1,186.36	$ 1,305
Oral Health Care	02002	1 vendor paid dollar for dental visit	$ 1.10	3.00	993.64	$ 1,093
Mental Health	03045	1 vendor paid adult individual - psychological	$ 1.10	2.00	590.91	$ 650
Emergency Financial Assistance	11029	1 other critical need dollar	$ 1.10	30.00	3,267.27	$ 3,594
Ambulatory Care	01008	1 vendor paid dollar for primary care visit w/HCP	$ 1.10	20.00	1,929.09	$ 2,122
	01009	1 vendor paid dollar for speciality care visit w/HCP	$ 1.10	1.00	54.55	$ 60
	01010	1 vendor paid dollar for lab visit	$ 1.10	2.00	239.09	$ 263
Case Management	14020	1 15 min Field-based face-to-face encounter	$ 16.75	35.00	2,280.72	$ 38,202
	14021	1 15-min Field-based other encounter	$ 16.75	35.00	327.28	$ 5,482
					3/1/15 - 6/30/15 TOTAL	$ 52,771

GRAND TOTAL	$ 472,578

SCHEDULE OF FEDERAL FUNDS

A.	Catalog of Federal Domestic Assistance (CFDA) number:	93.914
	CFDA Title:	HIV Emergency Relief Project Grants
	Award Name and Number:	Part A & MAI, 6 H89HA00048-17-03
	Award Year:	3/1/12 – 2/28/13
	Were funds awarded for research and development activities?	No
	Name of the Federal awarding agency:	Department of Health and Human Services - Health Resources and Services Administration
	Amount in this contract:	$104,755

B.	Catalog of Federal Domestic Assistance (CFDA) number:	93.914
	CFDA Title:	HIV Emergency Relief Project Grants
	Award Name and Number:	Part A & MAI, 6 H89HA00048-18-01
	Award Year:	3/1/13 – 2/28/14
	Were funds awarded for research and development activities?	No
	Name of the Federal awarding agency:	Department of Health and Human Services - Health Resources and Services Administration
	Amount in this contract:	$157,526

C.	Catalog of Federal Domestic Assistance (CFDA) number:	93.914
	CFDA Title:	HIV Emergency Relief Project Grants
	Award Name and Number:	Part A & MAI, 6 H89HA00048-19-01
	Award Year:	3/1/14 – 2/28/15
	Were funds awarded for research and development activities?	No
	Name of the Federal awarding agency:	Department of Health and Human Services - Health Resources and Services Administration
	Amount in this contract:	$157,526

Ryan White Program
CONTRACTOR BUDGET

Contractor: County of El Dorado
Contract Number: 7207500-13/15-709
Budget Term: July 1, 2012 through June 30, 2015

Effective Date: 7/1/2012
Contractor Budget Version#: 1

D.	Catalog of Federal Domestic Assistance (CFDA) number	93.914
	CFDA Title:	HIV Emergency Relief Project Grants
	Award Name and Number:	Part A & MAI, 6 H89HA00048-20-01
	Award Year:	3/1/15 – 2/28/16
	Were funds awarded for research and development activities?	No
	Name of the Federal awarding agency:	Department of Health and Human Services - Health Resources and Services Administration
	Amount in this contract:	$52,771

COUNTY APPROVAL

By: _____ Date: 12/4/12
Tracy L. Bennett, Acting Director, Department of Health and Human Services. Approval delegated pursuant to Sacramento County Code Section 2.61.012 (h)

CONTRACTOR APPROVAL

By: _____ Date: 8/21/12
John R. Knight, Chair, El Dorado County Board of Supervisors

ORIGINAL COPIES TO: Public Health, Contracts Unit, Fiscal, Auditor, Contractor

ATTEST: Terri Daly, Acting
Clerk of the Board of Supervisors
By _____ DEPUTY