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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Reorganization of Rules Intended to Provide Clarity and Readability.

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RULES:
410-123-0010, 410-123-1000, 410-123-1025, 410-123-1060, 410-123-1160, 410-123-1250, 410-123-1260, 410-123-1262, 410-123-1265, 410-123-1490, 410-123-1620

REPEAL: 410-123-0010

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be repealed: Content from this rule was moved to other sections of the Dental Services rule, Division 123.

CHANGES TO RULE:

~~410-123-0010~~
~~Foreword~~
~~(1) The Oregon Health Plan offers Medicaid dental/denturist benefits on a fee-for-service (FFS) basis and through Managed Care Entities (MCE). These rules are Division rules to give fee-for-service providers direction in the delivery of dental services and in the preparation of dental care claims.¶~~
~~(2) Managed Care Entities (MCE) provide dental/denturist services under an approved contract with the Authority. In accordance with 42 CFR 438.210, MCEs are required to provide medical and dental services in an amount, duration and scope. In accordance with 42 CFR 438.210, MCEs are required to provide medical and dental services in an amount, duration and scope that meets the minimum requirements for amount, duration and scope for the same services provided under FFS Medicaid., duration and scope for the same services provided under FFS Medicaid.¶~~
~~(a) MCEs must adhere to the Fee-for-Service Dental/Denturist Services rules in providing the minimum standard of care required per federal regulations and within the MCE's contract. MCEs may provide services above and beyond these rules, according to each contract agreement, State Plan, and 1115 Waiver.¶~~
~~(b) For clients enrolled in an MCE, refer to the MCE rules and contracts for services rendered above and beyond the minimum standard found within the Fee-for-Service Dental/Denturist Services rules or guides. The MCE has the authority to provide more services than those found in these rules, as long as the amount, duration and scope is no less than the amount, duration and scope for the same services provided in these rules.¶~~
~~(c) The Fee-for-Service Dental/Denturist rules do not list every policy, procedure, and criteria for services. All Division rules shall be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR chapter 410, division 120), and the Oregon Health Plan (OHP) Administrative Rules for Managed Care Entities~~

~~(OAR chapter 410, division 141).~~
~~Statutory/Other Authority: ORS 413.042, ORS 414.065~~
~~Statutes/Other Implemented: ORS 414.065~~

REPEAL: 410-123-1000

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be repealed: Content from this rule was moved to other sections of the Dental Services rule, Division 123.

CHANGES TO RULE:

~~410-123-1000~~
~~Eligibility, Services Reviewed by the Division, Billing and the Dental Billing Invoice~~
~~(1) Eligibility:¶~~
~~(a) Providers must verify client eligibility and benefit coverage of clients on each day of service, and shall do so before providing any service or billing to the:¶~~
~~(A) Oregon Health Authority (referred to as "Authority" throughout these rules);¶~~
~~(B) Health Systems Division (referred to as "Division" throughout these rules);¶~~
~~(C) Oregon Health Plan (referred to as "OHP" throughout these rules); or¶~~
~~(D) Managed Care Entity (referred to as "MCE" throughout these rules).¶~~
~~(b) A client medical identification card does not guarantee eligibility on the date of service. The Division shall does not pay reimburse for services provided to an ineligible client, even if services were authorized before a client loses benefit coverage due to changes in income, household size, redetermination status, or any other factor. Refer to General Rules OAR 410-120-1140 (Verification of Eligibility) for details.¶~~
~~(2) Services Reviewed by the Division:¶~~
~~(a) Services requiring Prior Authorization (PA): See OAR 410-123-1160 and 410-120-1320 for information about services that require PA or how to request PA.¶~~
~~(b) By Report Pricing:¶~~
~~(A) Most dental services are included in a standard fee schedule. However, some services are not included in the fee schedule because they are unique. Procedures for such services are "by report" meaning the provider shall submit a written report to justify the services;¶~~
~~(B) Dental services listed as "By Report" (BR) shall be submitted with an adequate definition or description of the nature, extent, and need for the procedure, the time, effort and necessary equipment medically necessary to provide the service, and any relevant operative or clinical history reports and/or radiographs. Payment for BR procedures will be approved in consultation with a Division dental consultant;¶~~
~~(C) Refer to the "Covered and Non-Covered Dental Services" data base, for a list of procedure codes noted as BR. See OAR 410-123-1220.¶~~
~~(3) Billing:¶~~
~~(a) Providers are prohibited from billing or seeking to collect payment from an OHP member (or any financially responsible relative or representative of that individual) for Medicaid covered services outside of any cost-sharing, coinsurance or copay required by the plan. See 42 CFR 447.20 (a) for more detail;¶~~
~~(b) For non-covered services, a provider may bill a Medicaid patient when all of the following conditions are met:¶~~
~~(A) The provider has an established policy for billing all patients for services not covered by a third party. The charges may not only apply to Medicaid patients;¶~~
~~(B) The patient is advised prior to receiving a non-covered service that Medicaid will not pay for the service;¶~~
~~(C) the patient or patient's parent or legal guardian agrees to be personally responsible for the service;¶~~
~~(D) An Agreement to Pay (OHP 3165/3166) form or other form that contains all of the elements of the OHP 3165/3166 is signed and dated by the patient;¶~~
~~(E) The patient's Medicaid Identification Card may not be held by the provider as guarantee of payment by the patient;¶~~
~~(F) The estimated fee for the service does not change;¶~~
~~(G) The procedure or service is provided within 30 days of the patient's signature.¶~~
~~(c) Providers shall follow the Division rules in effect on the date of service. All Division rules are intended to be used in conjunction with the Division's General Rules Program (chapter 410, division 120), the OHP Administrative Rules (chapter 410, division 141), Pharmaceutical Services Rules (chapter 410, division 121) and other relevant Division OARs applicable to the service provided, where the service is delivered, and the qualifications of the person providing the service including the requirement for a current signed provider enrollment agreement;¶~~
~~(d) Providers shall comply with OAR 410-120-1280 Billing rules and OAR 410-120-1360 requirements to develop and maintain adequate financial and clinical records and other Documentation that supports the specific care, items, or services for which payment has been requested:¶~~
~~(A) The Authority will only pay for services that are adequately documented;¶~~

(B) Documentation shall support the dates of service, the amounts billed, the specific services provided, who provided the services, and the medical necessity of those services;¶
(C) Financial records shall indicate that the amount billed to the Authority was appropriate and that all other resources were pursued before billing the Authority;¶
(D) FFS providers shall keep clinical information on file for seven years, and financial records five years. Providers contracted with an MCE shall retain all clinical records for a minimum of ten (10) years after the date of services for which claims are made, as in OAR 410-141-3520. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the retention period, the clinical records shall be retained until all issues arising out of the action are resolved.¶
(e) Third Party Resources: A Third Party Resource (TPR) is an alternate insurance resource, other than the Division, available to pay for medical/dental services and items on behalf of OHP clients. Any alternate insurance resource shall be billed before the Division or any OHP MCE can be billed. Indian Health Services or Tribal facilities are not considered to be a TPR pursuant to the Division's General Rules Program rule 410-120-1280;¶
(f) For Medicaid covered services, the provider shall not:¶
(A) Bill the Authority more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Authority program rules;¶
(B) Bill the client for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Authority;¶
(C) Bill the client for services or treatments that have been denied due to provider error (e.g., required Documentation not submitted, prior authorization not obtained, etc.).¶
(g) Refer to OAR 410-123-1160 for information regarding dental services requiring prior authorization (PA);¶
(h) The client's records shall include Documentation to support the appropriateness of the service and level of care rendered;¶
(i) The Division shall only reimburse for dental services that are Dentally Appropriate as defined in OAR 410-123-1060;¶
(j) Refer to OAR chapter 410, division 147 for information about reimbursement for dental services provided through a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC);¶
(k) Treatment Plans: Being consistent with established dental office protocol and the standard of care within the community, scheduling of appointments is at the discretion of the dentist. The agreed upon treatment plan established by the dentist and patient shall establish appointment sequencing. Eligibility for medical assistance programs does not entitle a client to any services or consideration not provided to all clients;¶
(L) Fabricated Prosthetics:¶
(A) If a dentist or denturist provides an eligible client with fabricated prosthetics that require the use of a dental laboratory, the date of the final impressions shall have occurred prior to the client's loss of eligibility;¶
(B) The dentist/denturist should use the date of final impression as the date of service only when criteria in (A) is met and the fabrication extends beyond the client's OHP eligibility;¶
(C) The date of delivery shall be within 45 days of the date of the final impression and the date of delivery shall also be indicated on the claim. All other services shall be billed using the date the service was provided.¶
(4) Billing Invoice:¶
(a) Providers shall refer to the Dental Services Provider Guide for information regarding claims submissions and billing information;¶
(b) Providers billing dental services on paper shall use the 2019 version of the American Dental Association (ADA) claim form;¶
(c) Submission of electronic claims directly or through an agent shall comply with the Electronic Data Interchange (EDI) rules. OAR 943-120-0100 et seq;¶
(d) Specific information regarding Health Insurance Portability and Accountability Act (HIPAA) requirements can be found on the Division Web site;¶
(e) Upon submission of a claim to the Authority for payment, the provider agrees that it has complied with all Authority program rules and understands that payment of the claim will be from federal and state funds, and that any falsification, or concealment of material fact, may be prosecuted under federal and state laws. Submission of a claim or encounter does not relieve the provider from the requirement of a signed provider enrollment agreement.¶
(5) A provider enrolled with the Authority shall bill using the Authority assigned provider number, or the National Provider Identification (NPI) number, pursuant to OAR 410-120-1260.¶
(6) Unless otherwise specified, claims shall be submitted after:¶
(a) Delivery of service; or¶
(b) Dispensing, shipment or mailing of the item.¶
(7) The provider shall submit true, accurate and complete information when billing the Division. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted

~~information.¶~~
~~(a) A claim is considered a valid claim only if it contains all data required for processing. See the appropriate provider rules and supplemental information for specific instructions and requirements;¶~~
~~(b) A provider or its contracted agency, including billing providers, may not submit or cause to be submitted:¶~~
~~(A) Any false claim for payment;¶~~
~~(B) Any claim altered in such a way as to result in a payment for a service that has already been paid;¶~~
~~(C) Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed., with the exception of OAR 410-120-1280(10)(c)(A-D). If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to the Authority. Any amount paid by the other source shall be clearly entered on the claim form;¶~~
~~(D) Any claim for furnishing specific care, items, or services that has not been provided;¶~~
~~(E) Any claim for specific care, items or services that is not supported by the Documentation, the member's treatment or care plan, as applicable, and compliant with program specific rules. All Documentation shall be complete and signed by the rendering provider prior to submitting a claim the Authority or MCE for payment.¶~~
~~(c) If an Overpayment has been made by the Authority, the provider shall do one of the following within 30 calendar days of the date on which the overpayment was identified:¶~~
~~(A) Adjust the original claim to show the Overpayment as a credit in the appropriate field;¶~~
~~(B) Submit an Individual Adjustment Request (OHP 1036);¶~~
~~(C) Adjust the claim on the Provider Web Portal available online at all times at: https://www.or-medicaid.gov;¶~~
~~(D) Refund the amount of the Overpayment on any claim;¶~~
~~(E) Void the claim via the Provider Web Portal if the Authority overpaid due to erroneous billing;¶~~
~~(F) If the Overpayment occurred because of a payment from a third party payer, refer to OAR 410-120-1280(10)(f) Billing rule.¶~~
~~(8) Procedure code requirement:¶~~
~~(a) For claims requiring a procedure code the provider shall bill as instructed in the appropriate Authority program rules and shall use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-PCS, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;¶~~
~~(b) For claims that require the listing of a procedure code as a condition of payment, the reported procedure code shall be supported by the client's medical record and the codes that most accurately describes the services provided. All providers, including Hospitals, billing the Authority shall follow national coding guidelines;¶~~
~~(c) When there is no appropriate descriptive procedure code to bill the Authority, the provider shall use the code for "unlisted services." A complete and accurate description of the specific care, item, or service shall be documented on the claim;¶~~
~~(d) Where there is one CPT, CDT, or HCPCS code that, according to CPT, CDT, and HCPCS coding guidelines or standards, describes an array of services, the provider shall bill the Authority using that code rather than itemizing the services under multiple codes. Providers may not "unbundle" services.~~
~~Statutory/Other Authority: ORS 413.042, ORS 414.065~~
~~Statutes/Other Implemented: ORS 414.065~~

REPEAL: 410-123-1025

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be repealed.

CHANGES TO RULE:

~~410-123-1025~~
~~Program Integrity and Provider Audits~~
~~(1) The Oregon Health Authority (Authority) uses several approaches to promote program integrity and preventing Fraud, waste and Abuse in the Medicaid program. OAR 410-120-1360 through 410-120-1580 generally describe Authority program integrity activities related to Medicaid providers and payment. Providers enrolled with the Authority or under contract with the Authority or the Department of Human Services (DHS) receiving payments from the Authority or DHS are subject to audit or other post payment review procedures for all payments applicable to items or services furnished or supplied by the provider to or on behalf of Authority or DHS clients.¶~~
~~(2) Providers shall comply with OAR 410-120-1510, OAR 461-195-0601 and the requirements therein for prompt reporting of Fraud, waste and Abuse in the Medicaid program:¶~~
~~(a) Providers shall report all suspected Fraud, waste and Abuse by a provider, including Fraud, waste or Abuse by its employees or in the Authority administration, to the Medicaid Fraud Control Unit (MFCU) of the Department of Justice (DOJ) or to the Authority's Office of Program Integrity (OPI). Information on how to report may be found online at all times: https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx;¶~~
~~(b) Providers shall report all suspected Fraud or Abuse by an Authority or DHS client to the DHS's Office of Payment and Recovery (OPAR) Fraud Investigations Unit (FIU). Information on how to report may be found online at all times: http://www.oregon.gov/OHA/HSD/OHP//Pages/Policy-General-Rules.aspx;¶~~
~~(c) Authority will take all actions necessary to investigate and respond to credible allegations of Fraud, waste and Abuse in the Medicaid program, including but not limited to suspending or terminating the provider from participation in the medical assistance programs, withholding payments or seeking recovery of payments made to the provider, or imposing other sanctions provided under OAR 410-120-1400, state laws or regulations. These actions and any outcome(s) will be reported to CMS, or other federal or state of Oregon entities, or law enforcement, as appropriate.¶~~
~~(3) Providers delivering goods or services to OHP members and receiving payment under Oregon's medical assistance programs may be audited by the Authority, MFCU, Oregon Secretary of State, the Department of Health and Human Services (DHHS), or their authorized representatives.¶~~
~~(a) The audit rules and procedures applicable to oral health providers and MCE participating providers are in OAR 410-120-1396. The Authority conducts periodic audits of providers to ensure proper payments are made based on requirements applicable to covered services, to ensure program integrity of the Authority or DHS medical programs as outlined in OAR 410-120-1260 and OAR 407-120-0310, recover Overpayments and uncover possible instances of Fraud, waste, and Abuse;¶~~
~~(b) Providers shall submit true, accurate, and complete claims and encounters to the Authority. The Authority treats the submission of a claim or encounter, whether on paper or electronically, as certification by the provider of the following: "This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim or encounter will be from federal and state funds, and that any falsification or concealment of a material fact maybe prosecuted under federal and state laws;"¶~~
~~(c) Providers shall maintain clinical, financial and other records, capable of being audited or reviewed, consistent with the requirements of OAR 410-120-1360 Requirements for Financial, Clinical and Other Records, and all rules applicable to the specific service or item in OAR Ch 410 and Ch 309;¶~~
~~(d) Access to records, inclusive of medical charts and financial records does not require authorization or release from a member if the purpose is:¶~~
~~(A) To perform billing review activities;¶~~
~~(B) To perform utilization review activities;¶~~
~~(C) To review quality, quantity, and medical appropriateness of care, items, and services provided;¶~~
~~(D) To facilitate payment authorization and related services;¶~~
~~(E) To investigate a client's contested case hearing request;¶~~
~~(F) To facilitate investigation by the MFCU or DHHS;¶~~
~~(G) Where review of records is necessary to the operation of the program.¶~~
~~(e) If a provider determines that a submitted claim or encounter is incorrect, the provider is obligated to submit, within 30 calendar days of the date on which the Overpayment was identified, an Individual Adjustment Request and refund the amount of the Overpayment, if any, consistent with the requirements of OAR 410-120-1280.~~

When the provider determines that an Overpayment has been made, the provider shall notify and reimburse the Authority immediately, following the reimbursement procedures in OAR 410-120-1397;¶
(f) Upon written request from the Authority, MFCU, Oregon Secretary of State, the DHHS, law enforcement agency or their authorized representatives the provider shall furnish, at the providers expense, requested Documentation immediately or within the time-frame specified in the request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of the Authority, Department, MFCU, or DHHS may, together or separately, review and copy the original Documentation in the provider's place of business;¶
(g) Payment may be denied or subject to recovery if a review or audit determines the care, service or item was not provided in accordance with Authority rules or does not meet the criteria for quality or medical appropriateness of the care, service or item or payment;¶
(h) PIAU will use the sampling methods and calculation of Overpayment methodology outlined in OAR 410-120-1396. When the Authority determines that an Overpayment has been made to a provider, the amount of Overpayment is subject to recovery;¶
(i) Prior to identifying an Overpayment, the Authority or designee may contact the provider for the purpose of providing preliminary information and requesting additional Documentation. Provider shall provide the requested documentation to Authority within the time frames requested, unless any good cause for an extension in OAR 410-120-1396 is shown;¶
(j) When an Overpayment is identified, the Authority will notify the provider in writing, as to the discrepancy, the method of computing the dollar amount of the Overpayment, and any further action that the Authority may take in the matter;¶
(k) The provider may appeal an Authority notice of Overpayment in the manner provided in OAR 410-120-1396:¶
(A) All Authority administrative review decisions are subject to procedures established in OAR 410-120-1396 and OAR 137-004-0080 to 137-004-0092 and judicial review under ORS 183.484 in the Circuit Court;¶
(B) The contested case hearing process is conducted in accordance with ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700 and OAR 410-120-1396.¶
(L) When Overpayment is identified in an audit finding, the Authority may recover Overpayments made to a provider by direct reimbursement, offset, civil action, or other actions authorized by law;¶
(m) Authority will suspend provider enrollment and any payments, all or in part, when a credible allegation of Fraud exists pursuant to federal law under 42 CFR 455.23, whether presented to the Authority, ODHS, DOJ MFCU, or law enforcement entity; unless there is a pending investigation and good cause exists to continue payment;¶
(n) In addition to any Overpayment, Authority may impose sanctions on a provider in connection with the actions that resulted in the Overpayment or pursue other remedies specific to contract(s) between the provider and Authority.¶
(4) Provider sanctions in OAR 410-120-1400 may result in suspension or termination of the provider enrollment and the provider's Division assigned provider number.¶
(5) Authority may communicate with and coordinate any program integrity actions with the MFCU, DHS, and other federal and state oversight authorities.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1060

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be Amended: This section provides Definitions and acronyms for the Dental/Denturist services program.

CHANGES TO RULE:

410-123-1060
Definition ~~of Ter~~and Acronyms ¶

(1) "A~~buse" has the meaning as provided in OAR 410-120-0000.¶~~
~~(2) "Acute" has the meaning as provided in OAR 410-120-0000.¶~~
~~(3) "Ambulatory Surgical Center (ASC)" has the meaning as provided in OAR 410-120-0000~~lveoplasty" is a dental procedure often performed following a tooth extraction, to help recreate the natural contour of the gums and jaw that may have been lost due to bone loss from tooth extraction, or for another reason.¶
(~~4~~2) "An~~esthesia~~cillary codes" a~~refers to the Oregon Board of Dentistry administrative rules (OAR chapter 818, division 026)~~ procedure codes for treatments or services that are not provided alone, but along with other treatments or services.¶
(~~5~~3) "Anesthesia Services" has the same meaning as provided in OAR 410-120-0000 and means administration of anesthetic agents to cause loss of sensation to the body or body part.¶
~~(6) "By Report (BR)" has the meaning as provided in OAR 410-120-0000~~ These services must be provided in accordance with Chapter 818, Division 26.¶
(~~7~~4) "~~Current Dental Terminology (CDT)" means a listing of descriptive terms identifying dental procedure and nomenclature used by the American Dental Association.¶~~
~~(8) "Citizenship Waived Medical" has the meaning as provided in OAR 410-120-0000. The acronym "CWM" has the same meaning~~Anterior teeth" are referred to as the front teeth. Permanent (adult) teeth are also referred to by numbers and differentiated by upper and lower: ¶
(a) The upper anterior teeth are indicated by the numbers 6, 7, 8, 9, 10, 11; and ¶
(b) The lower anterior teeth are indicated by the numbers 22, 23, 24, 25, 26, 27.¶
(~~9~~5) "~~CMS-416" means the annual EPSDT participation report required by Section 1902(a)(43)(D) of the Social Security Act, which assesses the Oregon Health Plan's effectiveness in providing screening and dental services for EPSDT eligible childr~~Apexification" is a dental treatment provided on permanent teeth when the roots of the teeth are incompletely formed, to encourage development ~~according to the appropriate periodicity schedule. For the purpose of the measurement, "Dental" services refer to services provided by or under the supervision of a dentist. "Oral health" services refer to services provided by a licensed practitioner that is not a dentist. For example, a pe~~nd formation of the root.¶
(6) "Apicoectomy" involves the removal of a tooth's root tip and surrounding tissue.¶
(7) "Bicuspid teeth" are permanent teeth, they have two points or cusps on the crown (chewing surface) and two points or cusps on the root:¶
(a) Upper bicuspid teeth are indicated by the numbers 4, 5, 12, 13; and¶
(b) Lower bicuspid teeth are indicat~~rician that applies a fluoride varnish, or an independently practic~~ed by the numbers 20, 21, 28, 29.¶
(8) "Billing" d~~ental hygienist not under the supervision of a dentist~~finition is provided in OAR 410-120-1280.¶
(~~10~~9) "~~Covered Services"~~By Report" (BR) has the meaning as provided in OAR 410-120-0000.¶
(~~11~~0) "C~~OVID-19 Emergency" means the period:¶~~
~~(a) Starting on the earliest of any COVID-19 public health emergency affecting the delivery of heal~~anine teeth" are anterior teeth that are pointed. In addition to numbered permanent (adult) teeth, primary (baby) teeth are also referred to by letters and differentiated between upper and lower.¶
(a) Primary upper canine teeth ~~c~~are ~~services and declared by the Secretary of HHS pursuant to 42 U.S.C. § 247d, by the Governor of Oregon, or by the Authority~~indicated by the letters C, H;¶
(b) Primary lower canine teeth are indicated by the letters M, R;¶
(c) Permanent upper canine teeth are indicated by the numbers 6, 11; and¶
(~~b~~d) ~~Ending on the latest of any COVID-19 public health emergency affecting the delivery of~~ Permanent lower canine teeth are indicated by the numbers 22, 27.¶
(11) "Composite restorations" are white/tooth colored¶
fillings. ¶
(12) "Current Dental Terminology (CDT)" codes are the al~~th care s~~phanumer~~vices and declared by the Secretary of HHS pursuant to 42 U.S.C. § 247d, by the Governor of Oregon, or by the Authority~~ codes that identify a specific

dental procedure, as designated by the federal government, and used by the American Dental Association.¶
(12~~3~~) "Dental" means ~~conditions having to do with the~~ teeth and supporting structures.¶
~~(13) "Dental Care Organization" (DCO) .¶~~
(14) "Dental Care Organization~~"~~ (DCO)" as provided for in ORS 414.025~~(24) means a pre-paid managed care health services organization that provides, either by contract with a coordinated care organization or through other mechanisms;~~ who provide the following:¶
(a) ~~d~~Dental services to the coordinated care organization's members, on a pre-paid capitated basis;~~ or~~ ¶
(b) ~~a~~Administrative services on behalf of the coordinated care organization as they relate to the delivery of dental services, including, without limitation: provider credentialing, prior authorization or denial of services, or encounter claims processing; or~~¶~~
~~(c) or both of the foregoing¶~~
(c) Both of the foregoing.¶
(15) "Dental Emergency Condition" means any incident involving the teeth and gums which may require immediate treatment to stop ongoing tissue bleeding, alleviate severe and sudden pain or infection, treat unusual swelling of the face or gums, or to preserve an avulsed tooth:¶
(a) Emergency conditions are based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which over-the-counter medications in the absence of immediate medical attention may not in fact have had the adverse results; and¶
(b) The treatment of an emergency dental condition is limited only to Covered Services. The Authority recognizes that some non-covered services may meet the criteria of treatment for the emergency condition. However, this rule does not extend to those non-covered services.¶
(15~~6~~) "Dental Emergency Services" has the meaning as provided in OAR 410-120-0000. For the purpose of ~~Division~~the Authority's rules, Dental Emergency Services is synonymous with emergency dental care and emergency oral health care.¶
(16~~7~~) "Dental Hygienist" has the meaning as provided in OAR 410-120-0000.¶
(17~~8~~) "Dental Hygienist with "Expanded Practice Dental Hygiene (EPDH) Permit ~~(EPDH)~~" has the meaning as provided in OAR 410-120-0000.¶
(18~~9~~) "Dental Practitioner" (practitioner) means an individual licensed pursuant to state law to engage in the provision of dental services within the scope of the practitioner's license and certification.¶
(~~19~~20) "Dental Services" has the meaning as provided in OAR 410-120-0000, and means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist or denture services provided within the scope of practice as defined under state law by a denturist or dental hygienist with an Expanded Practice Permit (EPP).¶
(20~~1~~) "Dental Services Documentation" means meeting the requirements of the Oregon Dental Practice Act statutes, administrative rules for ~~client~~member records and requirements of OAR 410-120 1360 Requirements for Financial, Clinical and Other Records, and any other ~~D~~ddocumentation requirements as outlined in OAR chapter 410 division 123 (Dental rules).¶
~~(21) "Dental Emergency Condition" means any incident involving the teeth and gums which would require immediate treatment to stop ongoing tissue bleeding, alleviate severe and sudden pain or infection, treat unusual swelling of the face or gums, or to preserve an avulsed tooth:¶~~
~~(a) Emergency conditions are based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results;¶~~
~~(b) The treatment of an emergency dental condition is limited only to Covered Services. The Division recognizes that some non-Covered Services may meet the criteria of treatment for the emergency condition; however, this rule does not extend to those non-Covered Service.¶~~
(22) "Dental Therapist" has the meaning provided in ORS 679.010.¶
(23) "Dentally Appropriate" has the meaning as provided in OAR 410-120-0000.¶
(24) "Dentist" has the meaning as provided in OAR 410-120-0000.¶
(25) "Denturist" has the meaning as provided in OAR 410-120-0000.¶
(26) "Distant Site" means the site where the dentist is being contacted for consultation by the originating site.¶
(27) "Documentation" means dental services documentation which meets the requirements of the Oregon Dental Practice Act statutes, administrative rules for ~~client~~member records and requirements of OAR 410-120 1360 Requirements for Financial, Clinical and Other Records, and any other documentation requirements as outlined in OAR chapter 410, division 123 (Dental/Denturist rules).¶
(28) "Early and Periodic Screening, Diagnos~~is~~tic, and Treatment (EPSDT)~~ Services~~" means the ~~federally mandated comprehensive and preventative child health program for individuals under the age of 21, under the Omnibus Budget Reconciliation Act of 1989 and Section 1905(r)(5) of the Social Security Act. Consistent with state and federal law and regulations, the OHP Dental Program ensures that all dentally necessary services and screenings~~

~~are provided, either directly or through an Authority contracted MCE for EPSDT~~ program requiring specific coverage for children and young adults, as described in OAR chapter 410, division 151.¶
(29) "EPSDT Beneficiary" means an individual under age 21 who is covered by the Oregon Health Plan. Young Adults with Special Health Care Needs (YSHCN) are included in EPSDT program benefits.¶
(30) "Electronic Data Interchange (EDI)" has the meaning as provided in OAR 943-120-0100.¶
(31) "Eligibility" has the meaning as provided in OAR chapter 410, division 200.¶
(32) "Emergency Dental Condition" means any incident involving the teeth and gums which may require immediate treatment to stop ongoing tissue bleeding, alleviate severe and sudden pain or infection, treat unusual swelling of the face or gums, or to preserve an avulsed (knocked out) tooth:¶
(a) Emergency conditions are based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention may not in fact have had the adverse results; and¶
(b) The treatments of emergency dental conditions are limited only to covered services. The Authority recognizes that some non-covered services may meet the criteria of treatment for the emergency condition; however, this rule does not extend to those non-covered services.¶
(~~29~~33) "~~Fee-for-Service Provider" has the meaning as provided in OAR 410-120-0000~~Endodontic" means relating to the inner tissues of teeth, otherwise known as the pulp or nerve. Endodontic treatments include pulpal therapy and root canal therapy.¶
(34) "Fillings" are provided when an area of decay on a tooth is removed by a dental provider , leaving a hole or space that is then filled with a material.¶
(3~~0~~5) "Fraud" has the meaning as provided in OAR 410-120-0000.¶
(3~~1~~6) "Gingivectomy" is the surgical removal of diseased gum tissue, to prevent damage to the bone.¶
(37) "Gingivoplasty" is the surgical reshaping of gum tissue around the teeth.¶
(38) "Health Care Interpreter (HCI)" means an individual who has been approved and certified by the Authority under ORS 413.558 to accurately interpret oral statements and documents to a person with limited English proficiency or in sign language. Qualified Health Care Interpreter has the same meaning.¶
(3~~2~~9) "~~Health Systems Division" has the meaning as provided in OAR 410-120-0000, and is within the Authority. The Division is responsible for managing the Oregon Health Plan (OHP), which is Oregon's Medicaid program.¶~~
~~(33) "Hospital Dentistry" means dental services normally done in a dental office setting but due to specific client need (as detailed in OAR 410-123-1490) are provided in an ambulatory surgical cent~~moglobin A1c (HbA1c)" is a measure of the amount of glucose attached to red blood cells and directly relates to average blood glucose levels.¶
(40) "Incisors" are anterior (front) teeth that have single, narrow edges. They are the four front, upper teeth, and the four front lower teeth. ¶
(a) Primary upper incisors are indicated by the letters D, E, F, G;¶
(b) Primary lower incisors are indicated by the letters N, O, P, Q;¶
(c) Permanent upp~~er, in~~~~patient or outpatient hospital setting under general anesthesia, or IV conscious sedation, if appropriate~~cisors are indicated by the numbers 7, 8, 9, 10; and;¶
(d) Permanent lower incisors are indicated by the numbers 23, 24, 25, 26.¶
(3~~4~~1) "Interpreter Services" means services available to those with Limited English Proficiency (LEP) as described in Title VI of the Civil Rights Act of 1964; Section 1557 of the Affordable Care Act; and ORS 413.550 ~~for~~ Meaningful Language Access Interpreter services may also be accessed for deaf or hard of hearing ~~patient~~members to ensure effective communication, as required by the Americans with Disabilities Act. The interpreter ~~shall~~must be a certified or qualified health care interpreter (HCI).~~¶~~
~~(3~~ (refer to chapter 950, division 50).¶
(42) "Malocclusion" is a misalignment or incorrect relation of the upper and lower teeth when the jaw is closed.¶
(43) "Mandibular" refers to the lower jaw and the lower teeth.¶
(44) "Maxillary" refers to the upper jaw and the upper teeth.¶
(45) "Managed Care Entity (MCE)" is a general term that means an entity that enters into one or more contracts with the Authority to provide services in a managed care delivery system, including but not limited to the following types of entities defined in and subject to 42 CFR Part 438: managed care organizations (MCOs), primary care case managers (PCCMs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs). A CCO is an MCE for its managed care contract(s) with the Authority, without regard to whether the contract(s) involves federal funds or state funds or both.¶
(3~~4~~6) "Maxillofacial" means relating to the face, head, neck or jaw. Treatments may be necessary due to congenital defects or caused by trauma or disease.¶
(47) "Medical Practitioner" means an individual licensed pursuant to state law to engage in the provision of medical services within the scope of the practitioner's license and certification.¶
(3~~7~~48) "Medically Necessary" has the meaning as provided in OAR 410-120-0000. ¶

(49) "Medicament" means a substance or combination of substances intended to be pharmacologically active, specially prepared to be prescribed, dispensed, or administered to prevent or treat disease.¶
(3850) "Oral Health" means conditions of therefers to the health of teeth, gums, lips, tongue, inner cheeks, soft and hard palate.¶
(39) "Oral Health Care" means services including, but not limited to, diagnostic, preventive, therapeutic, urgent, or emergency services provided by dental practitioners, dental specialists, dental hygienists, dentand the entire oral-facial system that allows us to smile, speak, and chew. Some of the most common diseases that impact our oral health include cavities (tooth decay), gum disease (periodontitis), and oral cancer.¶
(51) "Oral Heal-therapists, and trained primary care providers. In the dental field, oral health care and dental health care are used synonymously.¶
(40) "Oral Health Services" means services provided by a non-dentist (such as primary care physicians and nurse practitioners) and not under a dentist's supervision Services" refers to services offered to members for their improved oral health. The workforce involved in the services offered includes (but is not limited to) delivery systems staff, educational programs staff, licensed dental providers, dental assistants, and primary care providers such as doctors, nurses, and medical assistants.¶
(52) "Oregon Health Authority (Authority)" means the organization that administers Medicaid (Oregon Health Plan or OHP).¶
(4153) "Originating Site" means the site where the patientmember is located, and dental care providers are working and performing services in conjunction with a dentist who is not at that site, all while using telehealth technology.¶
(542) "Overpayment" has the meaning as provided in OAR 410-120-0000Periapical X-rays" capture an image of an entire tooth, from the crown to the root tip.¶
(4355) "Physician" has the meaning as provided in OAR 410-120-0000eriodontal scaling" and "root planing" refer to non-surgical treatments to remove plaque and tartar from teeth roots and gums.¶
(4456) "Prepaid Ambulatory Health Plans" has the meaning provided in 42 CFR 438.2eriodontal" refers to the soft tissues supporting and surrounding teeth.¶
(57) "Permanent teeth", often referred to as adult teeth, are the second set of teeth people get. There acronym "PAHP" has the same meaningre 32 permanent teeth which include incisors, canines, and premolars, and molars. They are identified by the numbers 1 through 32.¶
(458) "Primary Care Dentist (PCD)" as stated in OAR 410-120-0000, means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their membersosterior teeth" are referred to as the back teeth: ¶
(a) Permanent upper posterior teeth are indicated by the numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16;¶
(b) Permanent lower posterior teeth are indicated by the numbers 17, 18, 19, 20, 21, 28, 29, 30, 31, 32;¶
(c) Primary upper posterior teeth are indicated by the letters A, B, I, J; and¶
(d) Primary lower posterior teeth are indicated by the letters S, T, K, L.¶
(4659) "Primary Care Provider (PCP)" as statactitioner-Managed Prescription Drug Plan" (PMPDP) has the meaning provided in OAR 410-1201-0000, means any enrolled medical assistance provider who has 30.¶
(60) "Premolars" are permanent teeth and also called bicuspid teeth. They ares ponsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultationed between the canines and molars:¶
(a) The upper premolar teeth are indicated by the numbers 4, 5, 12, 13; and¶
(b)The lower premolar teeth are indicated by the numbers 20, 21, 28, 29.¶
(61) "Prepaid Ambulatory Health Plans (PAHP)" has the meaning provided in 42 CFR 438.2.¶
(62) "Prescriptions," meands specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or peervices as outlined in OAR 410-121-0144.¶
(63) "Primary Teeth" are also known as baby teeth. These are the first set of teeth that people get. There are 20 primary teeth that shall exfoliate (fall out) as the permanent teeth grow in. Primary teeth are indicatric medicine as defined in OAR 410-130-0005.¶
(47ed by the letters A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T. ¶
(64) "Prior Authorization" (PA) has the meaning as provided in OAR 410-120-0000. The acronym "PA" has the same meaning.¶
(48¶
(65) "Prioritized List of Health Services" (The List) means the comprehensive list of health services, ranked by priority, from the most important to the least important. The Oregon Health Plan benefits are made from The List and determined by the Oregon LegislaturePrioritized List)" has the meaning as provided in OAR 410-120-0000.¶
(4966) "Procedure Codes" means the procedure codes set forth in OAR chapter 410, division 123 that refer to Current Dental Terminology (CDT), unless otherwise noted. Codes listed in this rule and other documents

incorporated in rule by reference are subject to change by the American Dental Association (ADA) without notification.¶
(5067) "Providergram Integrity" has the meaning as provided in OAR 410-120-0001360 through 410-120-1580.¶
(5168) "Referral" as stated in OAR 410-120-0000, mProphylaxis" is a dental service to thoroughly cleans the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation eeth.¶
(69) "Prosthodontics" refers to the replacement of missing or damaged teeth with artificial devices, most commonly dentures.¶
(70) "Provider Audits" has the meaning as provided in OAR 410-120-1396.¶
(71) "Provider Responsibility" means to maintain clinical, financial, and other records consistent with OAR 410-120-1360.¶
(72) "Pulpal regeneration" is a dental treatment used to restore the pulp of a diseased or damaged tooth.¶
(73) "Pulpal therapy" involves removing pulp from the crown of a primary tooth and treating it with medicament.¶
(74) "Record retention" means the schedule whereby FFS providers must keep clinical information on file for sevaluation or a request or approval of specific serviceen (7) years, and financial records five (5) years. Providers contracted with MCE must refer to OAR 410-141-3520.¶
(75) "Scaling" is a deep-cleaning procedure for removing hardened tarter from teeth and roots.¶
(5276) "Standard of CarPractice" means what reasonable and prudent practitioners wouldmay do in the same or similar circumstances.¶
(5377) "Teledentistry" means the modes specified in OAR 410-123-1265, using electronic and telecommunications technologies, for the distance delivery of dental care services and clinical information designed to improve a patientmember's health status and to enhance delivery of the health care services and clinical information.¶
(54) "Telehealth" means for the purposes of OAR 410-123-1265, OAR 410-120-1990 and as specified in ORS 679.543, methods using electronic and telecommunications technologies for the distance delivery of health care services, including dental care services and clinical information designed to improve a patient's health status and to enhance delivery of (Refer to modes specified in OAR 410-123-1265).¶
(78) "Telehealth" has the meaning as provided in OAR 410-120-0000.¶
(79) "Third Party Resources (TPR)" has the hmealth care services and clinical informationning as provided in OAR 410-120-1280.¶
(5580) "Urgent Dental Care" means the management of conditions that require prompt attention to relieve pain and/or risk of infection and to alleviate the burden on hospital emergency departments. These shallconditions must be treated as minimally invasively as possible. Urgent dental care is distinguished from emergency dental care in that, urgent dental care requires prompt but not immediate treatment. Examples include dull toothache, mildly swollen gums, or small chips or cracks in teeth. Pregnant members shall be seen or treated for Urgent Dental care within one week and non-pregnant members within two weeks. Urgent care treatment is limited to covered services.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1160

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be Amended: This section provides the prior authorization requirements for the Dental/Denturist services program.

CHANGES TO RULE:

410-123-1160
Prior Authorization
(1) ~~Health Services Division (Division) p~~The following services require Prior ~~a~~Authorization (PA)~~ requirements. For fee-for-service (FFS) dental clients, the following services require PA:~~::¶
(a) Crowns: Porcelain fused to metal (D2751, D2752), Porcelain ceramic (D2740);¶
(~~a~~b) Crown~~s (porcelain fused to metal/porcelain ceramic);¶~~
~~(b) Crown repair~~ repair necessitated by restorative material failure, covered only for anterior teeth (D2980);¶
(c) Retreatment of previous root canal therapy~~ - anterior~~, covered only for anterior teeth (D3346);¶
(d) Complete dentures (D5110, D5120);¶
(e) Immediate dentures (D5130, D5140);¶
(f) Partial dentures (D5211, D5212, D5221, D5222);¶
(g) Prefabricated post and core in addition to fixed partial denture retainer;¶
(h) Fixed partial denture repairs (D6980);¶
(i) Skin graft~~;¶~~
~~(j) Orthodontics (when covered pursuant to OAR 410-123-126~~ (D7920);¶
(j) Comprehensive Orthodontic treatment (D8070, D8080, D8090)~~.~~;¶
(k) Hospital dentistry ~~always requires PA, regardless of the client's enrollment status.~~ (Refer to OAR 410-123-1490~~ for more information~~);¶
(~~L~~l) Oral surgical services~~ require PA,~~ when performed in an~~ a~~:¶
(A) Ambulatory surgical center (ASC); or~~ an o~~¶
(B) Outpatient or inpatient hospital setting and related anesthesia~~, and the current Medic~~ (Refer to OAR 410-130-0200);¶
(m) Maxillofacial ~~S~~surgical Services administrative rule OAR 410-130-0200 for information;eries, in some instances (Refer to OAR 410-130-0200).¶
(2) PA for more frequent non-surgical periodontal scaling and root planing (D4341, D4342) may be requested when:¶
(~~m~~a) M~~axillofacial surgeries may require PA in some instances. Refer to the current Medical Surgical Services OAR 410-130-0200, for information~~edically necessary and dentally appropriate due to periodontal disease found during pregnancy; and¶
(b) Documentation in the member's medical record supports the need for increased scaling and root planing.¶
(~~2~~3) The ~~Division~~Authority does not require PA for outpatient or inpatient services related to a "Dental Emergency Condition" ~~which means determination based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Profe~~as defined in OAR 410-123-1060.¶
(a) The member's clinical record must document any appropriate clinical information that supports the need for the hospitalization; and¶
(b) Refer to the Prioritized List of Health Services for funded emergency dental service codes.¶
(4) Periodontal maintenance is allowed once every six (6) months by PA when:¶
(a) Medically necessary and dentally appropriate (refer to EPSDT requirements in OAR chapter 410, division 151), such as due to presence of periodontal disease during pregnancy;¶
(b) Member's medical record documents the need;¶
(c) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and radiographs.¶
(5) Denture replacement requires PA.¶
(6) Hospital dentistry always requires PA for the medical services provided by the facility:¶
(a) If a member is enrolled in an MCE with plan type CCOA:¶
(A) The dentist is responsible for:¶
(i) Contacting the MCE for PA requirements and arrangements; and¶
(ii) Submitting documentation to the MCE associated with the member record.¶
(B) The MCE must review the documentation and discuss any concerns they have, contacting the dentist as needed; and¶
(C) The total response time must not exceed fourteen (14) calendar days from the date of submission~~al) and~~

~~includes cases in which the absence of immediate medical attention would not in fact have had the adverse results. The client's clinical record shall~~ of all required documentation for routine dental care and must follow urgent or emergent dental care timelines.¶
(b) If a member is enrolled in an MCE with plan type CCOB:¶
(A) The dentist is responsible for:¶
(i) Contacting the MCE for PA requirements and arrangements; and¶
(ii) Submitting documentation to the MCE associated with the member record.¶
(B) The MCE shall review the documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan (CCO and FFS) involvement and monitoring; and¶
(C) The MCE is responsible for payment of all facility and anesthesia services. The FFS program is responsible for payment of all dental services.¶
(c) If a member is enrolled in an MCE with plan type CCOF or CCOG and is enrolled in FFS for physical health, the:¶
(A) The Dentist is responsible for sending, by secure email or faxing, documentation an~~y~~d a~~ppropriate clinical information that supports the~~ completed American Dental Association (ADA) form to the Authority (Refer to the Dental Services Provider Guide);¶
(B) Member must have a referral from the PCM prior to any hospital service being approved by the Authority if assigneed ~~for the hospitalization. Refer to Line 54 of the Prioritized List of Health~~to a Primary Care Manager (PCM) through FFS medical, the;¶
(C) The Authority is responsible for payment of facility and anesthesia services;¶
(D) MCE is responsible for payment of all dental services; and¶
(E) The Authority shall issue a decision on PA requests within thirty (30) days of receipt of the request.¶
(d) If a member is FFS for both physical health and dental health or enrolled in MCE plan type CCOE, the:¶
(A) Dental provider is responsible for sending, by secure email or faxing, documentation, and a completed ADA form to the Authority (Refer to the Dental Services ~~for funded emergency~~Provider Guide); and¶
(B) Authority is responsible for payment of all facility, anesthesia services and dental service ~~code~~s.¶
(~~3~~7) How to request PA:¶
(a) Submit the request to the ~~Division~~Authority in writing. Refer to the Dental Services Provider Guide for specific instructions and forms to use. Telephone calls requesting PA ~~wi~~shall not be accepted;¶
(b) Documentation submitted when requesting authorization ~~shall~~must support the medical justification for the service. The authorization request ~~shall~~must contain:¶
(A) A cover sheet detailing relevant provider and recipient Medicaid numbers;¶
(B) Requested dates of service;¶
(C) HCPCS or Current Dental Terminology (CDT) Procedure code requested;¶
(D) Amount of service or units requested;¶
(E) Any additional clinical information supporting medical justification for the services requested.¶
(c) Treatment justification: The ~~Division~~Authority may request the treating dentist to submit appropriate radiographs or other clinical information that justifies the treatment:¶
(A) When radiographs are required, they ~~shall~~must be:¶
(i) Readable copies and of photo quality;¶
(ii) Mounted or loose;¶
(iii) In an envelope, stapled to the PA form;¶
(iv) Clearly labeled with the dent~~ist~~al provider's name and address and the ~~client~~member's name; and¶
(v) ~~I~~Of ~~digital x-ray, they shall be of photo qualit~~photo quality when it is a digital x-ray.¶
(B) Do not submit radiographs unless it is required by the Dental Services administrative rules, or they are requested during the PA process.¶
(~~4~~8) The ~~Division wi~~Authority shall issue a decision on PA requests within thirty (30) days of receipt of the request. The ~~Division wi~~Authority shall provide PA for services when:¶
(a) The prognosis is favorable;¶
(b) The treatment is practical;¶
(c) The services are ~~D~~medically necessary and dentally ~~A~~appropriate; and¶
(d) A lesser-cost procedure ~~would~~may not achieve the same ultimate results.¶
(~~5~~9) PA does not guarantee ~~client~~member eligibility or reimbursement. It is the responsibility of the provider to check the ~~client~~member's eligibility on each date of service.¶
(~~6) For certain services and billings, the Division wi~~10) The Authority shall seek a general practice consultant or an oral surgery consultant for ~~p~~:¶
(a) Professional review to determine if a PA ~~wi~~shall be approved~~. The Division wi~~; and¶
(b) Shall deny PA if the consultant decides that the clinical information furnished does not support the treatment of services.¶

~~(7) For hospital dentistry, refer to OAR 410-123-1490 for details regarding PA requirements.~~
Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.707
Statutes/Other Implemented: ORS 414.065, 414.707

AMEND: 410-123-1250

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be Amended: This section provides guidance for HbA1c for the Dental/Denturist services program.

CHANGES TO RULE:

410-123-1250
~~Dental~~ HbA1c Testing
(1) Hemoglobin A1c ~~is a measure of the amount of glucose attached to red blood cells and directly relates to average blood glucose levels.¶~~
~~(a) Dental~~ (HbA1c) testing for at risk ~~patient~~members is within the scope of dental practice for Oregon licensed oral health providers.¶
(2) Although not presumed to be a standard of care, testing serves as a resource for dentists which supports identification of those ~~patient~~members with HbA1c levels that are above the "normal range", and that can affect periodontal status, wound healing, infection control and other conditions of the oral environment~~;~~.¶
(~~b~~3) ~~The Authority and the Oregon Board of Dentistry have determined that licensed oral health providers shall refer patients, once identified with HbA1c levels above normal range, to their primary care provider for evaluation, diagnosis and treatment.¶~~
~~(2) Licensed oral health providers shall~~Licensed oral health providers must share the HbA1c test results with the ~~patient~~member's primary care provider (PCP) to promote care collaboration and avoid duplication~~.~~:¶
(a) If the test results ~~of the test~~ indicate risk, the dental provider ~~shall~~must establish bi-directional communication with the ~~patient's primary care provider~~member's PCP to communicate test results and initiate a referral for evaluation, diagnosis ~~and,~~ treatment, and collaborate ~~-~~ion of care~~,~~; and ~~c~~¶
(b) Communicate progress of treatment and oral health status.¶
(~~3~~4) Licensed oral health providers ~~shall~~must comply with OAR 410-130-0680, as it pertains to blood testing, and 42 CFR 493 and OAR 333-024-0005 through 333-024-0055, as it pertains to Clinical Laboratory Improvement Amendments (CLIA) ~~f~~:¶
(a) For laboratory enrollment requirements and processes, as identified at https://www.oregon.gov/oha/PH/LaboratoryServices/ClinicalLaboratoryRegulation/Pages/index.aspx~~.~~;¶
(4b) Oregon licensed oral health providers and facilities ~~shall~~must apply for a Certificate of Waiver (CMS 1600), available on the CLIA webpage, in order to perform any HbA1c testing~~.~~; and¶
(c) Waived tests are not exempt from CLIA certification, as stated on the website (Refer to https://www.cms.gov/medicare/quality/clinical-laboratory-improvement-amendments) and the CMS 1600.¶
(5) In determining the need for dental HbA1c testing, dentists ~~shall take into account patient~~must consider member risk factors based on appropriate, consensus-based guidelines and the dentist's best clinical judgement.¶
(6) Release of Information (ROI):¶
(a) Providers ~~shall~~must ensure a ~~patient release of information~~member's ROI is on file in the ~~patient~~member's record ~~in order to provide the HbA1c test and to make the needed referral, referenced in section (2) of this rule, to the patient's p~~;¶
(b) Shall the member not have a Primary ~~c~~Care ~~p~~Provider ~~for further evaluation, diagnosis and treatment;¶~~
~~(b) Should the patient not have a~~ (PCP), providers ~~shall~~must:¶
(A) Inform the ~~patient~~member of the test findings and direct them toward resources containing more information and encourage the member to become a ~~physician's~~ patient of record with a PCP for their other health needs; and¶
(B) Document actions in the ~~patient~~member's record, with follow-up at the next visit.¶
(c) Referrals ~~shall~~must be tracked and documented in the ~~patient~~member's record;¶
(d) ~~Patients may decline testing.~~ Providers ~~shall~~must provide sufficient information regarding the purpose of the test and the procedure, including its relevance to both oral and general health, so that a~~n informed patient decision can be made.¶~~
~~(7) Frequency of testing requirements and limitations:¶~~
~~(a) Providers shall perform HbA1c testing on the same patient no more frequently than annually unless the dentist determines it medically/dentally necessary to test more frequently due to unexplained progression of periodontal disease, delayed wound healing or recurrent oral candida infection. HbA1c should not be tested more frequently than every 3 months;¶~~
~~(b) The Division shall reimburse providers using D0411, and in alignment with OAR 410-130-0680, once per day, regardless of the frequency performed for drawing/collecting blood via capillary puncture.¶~~
~~(8) Coding and reimbursement:¶~~

~~(a) Dental HbA1c testing is completed under CDT code D0411, using modifier QW, and submitted on a CMS 1500 professional claim form, instructions found at https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Medical-Surgical.aspx - Professional Billing Instructions. The D0411 billing code allows for separate specific billing and data environments for HbA1c testing done in the dental environment and avoids crossover into the medical billing or data streams;¶~~
~~(b) The rate for reimbursement is found at https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx, effective January 1, 2020~~ member can make an informed decision; and¶
(e) Members may decline testing.
Statutory/Other Authority: ORS 679.543, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1260

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be Amended: This section provides guidance on coverage, limitations, and exclusions for the Dental/Denturist services program.

CHANGES TO RULE:

410-123-1260
~~OHP Dental Benefits~~Coverage, Limitations, Exclusions. ¶

(1) Th~~is administrative rule aligns with and reflects changes in relation to the American Dental Association (ADA) diagnosis and treatment pairs that are above the funding line and consistent with treatment guidelines on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List of Health Services or List) found in OAR 410-141-3830 and not otherwise excluded under OAR 410-141-3825.¶~~
~~(2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):¶~~
~~(a) Medicaid-eligible participants from birth up through the day before their twenty-first birthday are eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. This benefit covers age-appropriate screening visits and medically necessary Medicaid-covered services to treat identified physical, dental, developmental, and mental health conditions;¶~~
~~(b) Oregon's Medicaid and CHIP State Plans lists services covered under the OHP benefit package;¶~~
~~(c) For children over age one, Oregon's Medicaid 1115 Demonstration Waiver covers all EPSDT medically necessary services that are included on the prioritized list;¶~~
~~(d) Dental providers shall deliver EPSDT Dental Health Care screening visits and services at age-appropriate intervals following the "Oregon Health Plan (OHP) - Recommended Dental Periodicity Schedule," dated April 1, 2018, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document at: https://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Dental.aspx;¶~~
~~(e) Dental providers shall establish the delivery of routine preventive care services to children referred from primary care providers who deliver Dental screenings and fluoride varnish services in the medical setting;¶~~
~~(f) Prior Authorization and Referral requirements are imposed on medical and dental service Providers under EPSDT. Such requirements are designed as tools for determining a service, treatment or other measure meets the standards in subsection 2(c) of this section. The Authority determines which treatment to cover based upon the Provider's recommendations, current clinical guidance, and availability of equally effective alternative treatments;¶~~
~~(g) Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B which were in effect as of January 01, 1998. EPSDT services shall be medically or dentally necessary, and include, but are not limited to:¶~~
~~(A) Dental preventive screening services;¶~~
~~(B) Dental diagnosis and Dentally Necessary treatment that is indicated by screening at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.¶~~
~~(3) Dental Screenings (D0190) and Assessments (D0191):¶~~
~~(a) Dental screenings (D0190) including state or federally mandated screenings, are to determine an individual's need to be seen by a dentist for diagnosis. Reimbursement for D0190 is for credentialed providers who hold a certificate of completion from Smiles for Life or First Tooth;¶~~
~~(b) Dental assessments (D0191) are limited clinical inspections performed to identify possible signs of oral systemic disease, malformation, or injury, and the potential need for referral diagnosis and treatment. ¶~~
~~(A) Reimbursement for D0191 is for the following credential provider types:¶~~
~~(i) Licensed or certified dental professionals whose scope of practice includes assessing oral health; ¶~~
~~(ii) Physicians (MD or DO), advance practice nurses, or licensed physician assistants who hold a certificate of completion from Smiles for Life or First Tooth.¶~~
~~(B) The assessment tool used shall be endorsed by the American Dental Association, the American Academy of Pediatric Dentistry, the Association of State and Territorial Dental Directors, or the American Academy of Pediatrics;¶~~
~~(C) Referrals for identified dental needs or for the establishment of a dental home are to be made to the member's primary care dentist for FFS members, or to the member's CCO;¶~~
~~(D) Provide anticipatory guidance and counseling with the client's caregiver on good dental hygiene practices and nutrition;¶~~
~~(E) Document in the medical chart risk assessment findings and service components provided.¶~~
~~(c) Topical fluoride treatment - D1206 or 99188:¶~~

(A) May be applied during any well-child visit for children under 21 years of age;¶
(B) If a medical provider delegates this procedure to a staff member, the staff member shall be trained on the application of fluoride varnish;¶
(C) Limited to two treatments yearly for children with low risk of tooth decay;¶
(D) Limited to four treatments yearly for children with high risk of tooth decay. Provider shall document visible decay and risk in patient chart;¶
(E) Fluoride treatment may be performed and billed during a separate well-child or preventative care visit from dental assessment;¶
(F) Use CDT code D1206 or CPT code 99188 and the appropriate ICD-10 fluoride administration code in the professional claim format as directed by the First Tooth or Smiles for Life program guide.¶
(G) CDT code D0190 is limited to use for mass screenings of children or non-dental professionals during EPSDT well-child and preventative care visits.¶
(d) Referrals:¶
(A) If, during the screening process (periodic or inter-periodic), a dental, medical, substance abuse, or medical condition is discovered, the client shall be referred to an appropriate provider for further diagnosis and/or treatment;¶
(B) The screening provider shall explain the need for the Referral to the client, client's parent, or guardian;¶
(C) If the client, client's parent, or guardian agrees to the referral, assistance in finding an appropriate provider and making an appointment should be offered;¶
(D) The child's FFS provider or the MCE program will also make available care coordination as needed.¶
(4) DIAGNOSTIC SERVICES (D0100 - D0999):¶
(a) Clinical Dental evaluations (Exams):¶
(A) For children under 19 years of age:¶
(i) The Division shall reimburse exams (billed as CDT codes D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations:¶
(I) D0150: once every 12 months when performed by the same practitioner;¶
(II) D0150: twice every 12 months only when performed by different practitioners;¶
(III) D0180: once every 12 months.¶
(ii) The Division shall reimburse D0160 only once every 12 months when performed by the same practitioner.¶
(B) For adults 19 years of age and older, the Division shall reimburse exams (billed as CDT codes D0120, D0150, D0160, or D0180) once every 12 months;¶
(C) For problem focused exams (urgent or emergent problems), the Division shall reimburse D0140 for the initial exam. The Division shall reimburse D0170 for related problem-focused follow-up exams. Providers shall not bill D0140 and D0170 for routine dental visits;¶
(D) The Division only covers dental exams performed by Medical Practitioners when the Medical Practitioner is an oral surgeon. The surgeon may hold a dual degree, but shall bill as an oral surgeon;¶
(E) As the American Dental Association's Current Dental Terminology (CDT) codebook specifies, the evaluation, diagnosis, and treatment planning components of the exam are the responsibility of the Dentist. The Division may not reimburse dental exams when performed by a Dental Hygienist (with or without an expanded practice permit).¶
(b) Assessment of a patient (D0191):¶
(A) When performed by a Dental Practitioner, the Division shall reimburse:¶
(i) If performed by a Dentist outside of a dental office;¶
(ii) If performed by a Dental Hygienist with an expanded practice dental hygiene permit, or a licensed dental therapist;¶
(iii) If performed by physicians (MD or DO), advance practice nurses, or licensed physician assistants who hold a certificate of completion from Smiles for Life or First Tooth;¶
(iv) Only if an exam (D0120-D0180) is not performed on the same date of service. Assessment of a Patient (D0191) is included as part of an exam (D0120-D0180);¶
(v) For children under 19 years of age, a maximum of twice every 12 months; and¶
(vi) For adults age 19 and older, a maximum of once every 12 months. ¶
(B) An assessment does not take the place of the need for dental evaluations/exams.¶
(c) Diagnostic imaging:¶
(A) The Division shall reimburse for routine imaging once every 12 months;¶
(B) The Division shall reimburse bitewing radiographs for routine screening once every 12 months;¶
(i) D0240, D0250, D0251, D0273, D0274, D0277, D0321, D0322, D0701 - D0709 reimbursed once ever 12 months for all clients;¶
(ii) D0210, D0330 reimbursed once every five years, unless D0210 has been billed within the five-year period.¶
(C) The Division shall reimburse a maximum of six images for any one emergency;¶

(D) For clients under age six, images may be billed separately every 12 months as follows:¶
(i) D0220 - once;¶
(ii) D0230 - a maximum of five times;¶
(iii) D0270 - a maximum of twice, or D0272 once.¶
(E) The Division shall reimburse for panoramic radiographic image or intra-dental complete series once every five years, but both cannot be done within the five-year period;¶
(F) Clients shall be a minimum of six years old for billing intra-dental complete series. The minimum standards for reimbursement of intra-dental complete series are:¶
(i) For clients age six through 11 - a minimum of ten periapicals and two bitewings for a total of 12 films;¶
(ii) For clients ages 12 and older - a minimum of ten periapicals and four bitewings for a total of 14 films.¶
(G) If fees for multiple single radiographs exceed the allowable reimbursement for a intraoral-complete series (full mouth), the Division shall reimburse for the complete series;¶
(H) Additional films may be covered if dentally or medically appropriate, e.g., fractures (refer to OAR 410-123-1060 and 410-120-0000);¶
(I) If the Division determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area may be denied;¶
(J) The exception to these limitations is if the client is new to the office or clinic and the office or clinic is unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting Documentation outlining the provider's attempts to receive previous records shall be included in the client's records;¶
(K) Digital radiographs, if printed, shall be on photo paper to assure sufficient quality of images.¶
(5) PREVENTIVE SERVICES (D1000-D1999):¶
(a) Dental prophylaxis:¶
(A) For children under 19 years of age - Limited to twice per 12 months;¶
(B) For adults 19 years of age and older - Limited to once per 12 months;¶
(C) Additional prophylaxis benefit provisions may be available for persons with high risk dental conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily Dental Health Care.¶
(b) Topical fluoride treatment:¶
(A) For adults 19 years of age and older - Limited to once every 12 months;¶
(B) For children under 19 years of age - Limited to twice every 12 months;¶
(C) Additional topical fluoride treatments may be available, up to a total of four treatments per client within a 12-month period, when high-risk conditions or dental health factors are clearly documented in chart notes for clients who:¶
(i) Have high-risk dental conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;¶
(ii) Are pregnant;¶
(iii) Have physical disabilities and cannot perform adequate, daily Dental Health Care;¶
(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily Dental Health Care; or¶
(v) Are under seven years old with high-risk dental health factors, such as poor dental hygiene, deep pits, and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.¶
(D) Fluoride limits include any combination of fluoride varnish or other topical fluoride.¶
(c) Sealants:¶
(A) Are covered only for children under 16 years of age;¶
(B) The Division limits coverage to:¶
(i) Permanent molars; and¶
(ii) Only one sealant treatment per molar every five years, except for visible evidence of clinical failure.¶
(d) Tobacco cessation:¶
(A) For services provided during a dental visit, bill as a dental service using CDT code D1320 when the following 5 step counseling is provided:¶
(i) ASK: Identify the patient's tobacco-use status at each visit and record information in the chart;¶
(ii) ADVISE: Using a strong personalized message, advise patients on their dental health conditions related to tobacco use and give direct advice to quit using tobacco and seek help; and¶
(iii) ASSESS: If the tobacco user is willing to make a quit attempt, refer patient to external resources or internal counseling and intervention protocol.¶
(iv) ASSIST: If dental provider chooses to assist, provide counseling and pharmacotherapy to help patient quit tobacco.¶
(v) ARRANGE: Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date.¶

(B) The Division allows a maximum of ten services within a three-month period.¶
(e) Space maintenance (passive appliances):¶
(A) The Division shall cover fixed and removable space maintainers only for clients under 19 years of age;¶
(B) The Division may not reimburse for replacement of lost or damaged removable space maintainers.¶
(f) Interim caries arresting Medicament application (D1354/D1355): When used to represent silver diamine fluoride (SDF) applications for the treatment (rather than prevention) of caries, is limited to:¶
(A) Two applications per year;¶
(B) Requires that the tooth or teeth numbers be included on the claim;¶
(C) Shall be covered with topical application of fluoride when performed on the same date of service when treating a carious lesion;¶
(D) Shall be covered with an interim therapeutic restoration (D2941) or a permanent restoration and (D1354/D1355) on the same tooth, when Dentally Appropriate.¶
(g) Interim caries arresting Medicament application (D1354) is also included on The List to arrest or reverse noncavitated carious lesions. See The List Guideline Note 91 for more detail.¶
(6) RESTORATIVE SERVICES (D2000-D2999):¶
(a) Amalgam and resin-based composite restorations, direct:¶
(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;¶
(B) The Division reimburses posterior composite restorations at the same rate as amalgam restorations;¶
(C) The Division limits payment for replacement of posterior composite restorations to once every five years;¶
(D) The Division limits payment of covered restorations to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) CDT codebook for definitions of restorative procedures;¶
(E) Providers shall combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces);¶
(F) The Division may not reimburse for an amalgam or composite restoration and a crown on the same tooth;¶
(G) Interim therapeutic restoration on primary dentition is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration;¶
(H) Reattachment of tooth fragment is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment;¶
(I) The Division reimburses for a surface not more than once in each treatment episode regardless of the number or combination of restorations;¶
(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration.¶
(b) Indirect crowns and related services:¶
(A) General payment policies:¶
(i) The fee for the crown includes payment for preparation of the gingival tissue;¶
(ii) The Division shall cover crowns only when:¶
(I) There is significant loss of clinical crown and no other restoration will restore function; and¶
(II) The crown-to-root ratio is 50:50 or better, and the tooth is restorable without other surgical procedures.¶
(iii) The Division shall cover core buildup only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50 percent of the tooth structure shall be remaining for coverage of the core buildup;¶
(iv) Reimbursement of retention pins is per tooth, not per pin.¶
(B) The Division shall not cover the following services:¶
(i) Endodontic therapy alone (with or without a post);¶
(ii) Aesthetics (cosmetics);¶
(iii) Crowns in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason.¶
(C) Prefabricated stainless steel crowns are allowed only for anterior primary teeth and posterior permanent or primary teeth;¶
(D) The Division shall cover the following only for clients under 21 years of age or who are pregnant:¶
(i) Prefabricated resin crowns are allowed only for anterior teeth, permanent or primary;¶
(ii) Prefabricated stainless-steel crowns with resin window are allowed only for anterior teeth, permanent or primary;¶
(iii) Prefabricated post and core in addition to crowns;¶
(iv) Permanent crowns (resin-based composite - D2710 and D2712, porcelain fused to metal (PFM) - D2751 and D2752), and porcelain ceramic - D2740 as follows:¶
(I) Limited to teeth numbers 6-11, 22, and 27 only, if Dentally Appropriate;¶
(II) Limited to four in a seven-year period. This limitation includes any replacement crowns allowed.¶

(III) Only for clients at least 16 years of age; and¶
(IV) Rampant caries are arrested, and the client demonstrates a period of dental hygiene before prosthetics are proposed.¶
(v) Porcelain fused to metal, and porcelain ceramic crowns shall also meet the following additional criteria:¶
(I) The Dental Practitioner has attempted all other Dentally Appropriate restoration options and documented failure of those options;¶
(II) Written Documentation in the client's chart indicates that PFM is the only restoration option that will restore function;¶
(III) The Dental Practitioner submits radiographs to the Division for review. History, diagnosis, and treatment plan may be requested. (See OAR 410-123-1100 Services Reviewed by the Division);¶
(IV) The client has documented stable periodontal status with pocket depths within 1-3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeters and over, Documentation shall be maintained in the client's chart of the Dentist's findings supporting stability and why the increased pocket depths will not adversely affect expected long-term prognosis;¶
(V) The crown has a favorable long-term prognosis; and¶
(VI) If the tooth to be crowned is a clasp/abutment tooth in partial denture, both prognosis for the crown itself and the tooth's contribution to partial denture shall have favorable expected long-term prognosis.¶
(E) Crown replacement:¶
(i) Permanent crown replacement limited to once every seven years;¶
(ii) All other crown replacement limited to once every five years; and¶
(iii) The Division may make exceptions to crown replacement limitations due to Acute trauma, based on the following factors:¶
(I) Extent of crown damage;¶
(II) Extent of damage to other teeth or crowns;¶
(III) Extent of impaired mastication;¶
(IV) Tooth is restorable without other surgical procedures; and¶
(V) If loss of tooth would result in coverage of removable prosthetic.¶
(F) Crown repair is limited to only anterior teeth.¶
(7) ENDODONTIC SERVICES (D3000-D3999):¶
(a) Endodontic therapy:¶
(A) Pulpal therapy on primary teeth is covered only for clients under 21 years of age;¶
(B) For permanent teeth:¶
(i) Anterior and bicuspid endodontic therapy is covered for all OHP Plus clients; and¶
(ii) Molar endodontic therapy:¶
(I) For clients through age 20, is covered only for first and second molars; and¶
(II) For clients age 21 and older who are pregnant, is covered only for first molars.¶
(C) The Division covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures.¶
(b) Endodontic retreatment and apicoectomy:¶
(A) The Division may not cover retreatment of a previous root canal or apicoectomy for bicuspid or molars;¶
(B) The Division limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:¶
(i) Crown-to-root ratio is 50:50 or better;¶
(ii) The tooth is restorable without other surgical procedures; or¶
(iii) If loss of tooth would result in the need for removable prosthodontics.¶
(C) Retrograde filling is covered only when done in conjunction with a covered apicoectomy of an anterior tooth.¶
(c) The Division does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service or if the same practitioner or Dental Practitioner in the same group practice completed the procedure;¶
(d) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;¶
(e) Apexification/recalcification procedures:¶
(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;¶
(B) Apexification/recalcification procedures are covered only for clients under 21 years of age or who are pregnant.¶
(8) PERIODONTIC SERVICES (D4000-D9999):¶
(a) Surgical periodontal services:¶
(A) Gingivectomy/Gingivoplasty - limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to dental hygiene procedures, e.g., Dilantin hyperplasia; and¶
(B) Includes six months routine postoperative care;¶

(C) The Division shall consider gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) as part of the restoration and will not provide a separate reimbursement for this procedure.¶
(b) Non-surgical periodontal services:¶
(A) Periodontal scaling and root planing:¶
(i) Allowed once every two years;¶
(ii) A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;¶
(iii) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets of 5 mm or greater:¶
(I) D4341 is allowed for quadrants with at least four or more teeth with pockets of 5 mm or greater. Single implants may now be covered by counting the implant as an additional tooth when billing D4341. The maximum number per quadrant and pocket depth requirements still apply;¶
(II) D4342 is allowed for quadrants with at least two teeth with pocket depths of 5 mm or greater. Single implants may now be covered by counting the implant as an additional tooth when billing D4342. The maximum number per quadrant and pocket depth requirements still apply.¶
(iv) Prior Authorization for more frequent scaling and root planing may be requested when:¶
(I) Medically/Dentally Necessary due to periodontal disease as defined above is found during pregnancy; and¶
(II) Client's medical record is submitted that supports the need for increased scaling and root planing.¶
(B) Full mouth debridement allowed only once every two years.¶
(C) Scaling in the presence of generalized moderate or severe gingival inflammation - full mouth, after dental evaluation, allowed only once every two years.¶
(c) Periodontal maintenance allowed once every six months:¶
(A) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;¶
(B) Prior Authorization for more frequent periodontal maintenance may be requested when:¶
(i) Medically/Dentally Necessary, such as due to presence of periodontal disease during pregnancy; and¶
(ii) Client's medical record is submitted that supports the need for increased periodontal maintenance (chart notes, pocket depths and radiographs).¶
(d) Records shall clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;¶
(e) The Division may not reimburse for procedures identified by the following codes if performed on the same date of service:¶
(A) D1110 (Prophylaxis - adult);¶
(B) D1120 (Prophylaxis - child);¶
(C) D4210 (Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant);¶
(D) D4211 (Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant);¶
(E) D4341 (Periodontal scaling and root planning - four or more teeth per quadrant);¶
(F) D4342 (Periodontal scaling and root planning - one to three teeth per quadrant);¶
(G) D4346 (Scaling in presence of generalized moderate to severe inflammation, full mouth after dental evaluation);¶
(H) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and¶
(I) D4910 (Periodontal maintenance).¶
(9) PROSTHODONTICS, REMOVABLE (D5000-D5899):¶
(a) Clients age 16 years and older are eligible for removable resin base partial dentures and full dentures;¶
(b) See OAR 410-123-1000 for detail regarding billing fabricated prosthetics;¶
(c) The fee for the partial and full dentures includes payment for adjustments during the six-month period following delivery to clients;¶
(d) Resin partial dentures:¶
(A) The Division may not approve resin partial dentures if stainless steel crowns are used as abutments;¶
(B) For clients through age 20, the client shall have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;¶
(C) For clients age 21 and older, the client shall have one or more missing anterior teeth or six or more missing posterior teeth per arch with Documentation by the provider of resulting space causing serious impairment to mastication. Third molars are not a consideration when counting missing teeth;¶
(D) The Dental Practitioner shall note the teeth to be replaced and teeth to be clasped when requesting Prior Authorization (PA).¶
(e) Replacement of removable partial or full dentures, when it cannot be made clinically serviceable by a less costly

~~procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:¶~~
~~(A) For clients at least 16 years of age, the Division shall replace:¶~~
~~(i) Full dentures once every ten years, only if Dentally Appropriate;¶~~
~~(ii) Partial dentures once every five years, only if Dentally Appropriate.¶~~
~~(B) The five- and ten-year limitations apply to the client regardless of the client's OHP or MCE enrollment status at the time the client's last denture or partial was received. For example: A client receives a partial on February 1, 2020 and becomes a FFS OHP client in 2023. The client is not eligible for a replacement partial until February 1, 2025. The client gets a replacement partial on February 3, 2025 while FFS and a year later enrolls in an MCE. The client would not be eligible for another partial until February 3, 2030, regardless of MCE or FFS enrollment;¶~~
~~(C) Replacement of partial dentures with full dentures is payable five years after the partial denture placement. Exceptions to this limitation may be made in cases of Acute trauma, natural disaster, or catastrophic illness that directly or indirectly affects the dental condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily dental hygiene may not warrant replacement.¶~~
~~(f) The Division limits reimbursement of adjustments and repairs of dentures that are needed beyond six months after delivery of the denture as follows for clients 21 years of age and older:¶~~
~~(A) A maximum of four times per year for:¶~~
~~(i) Adjustments to dentures, per arch. Full and partial (D5410 - D5422);¶~~
~~(ii) Replace missing or broken teeth - complete denture, each tooth (D5520);¶~~
~~(iii) Replace broken tooth on a partial denture - each tooth (D5640);¶~~
~~(iv) Add tooth to existing partial denture (D5650).¶~~
~~(B) A maximum of two times per year for:¶~~
~~(i) Repair broken complete denture base (D5511, D5512);¶~~
~~(ii) Repair resin partial denture base (D5611, D5612);¶~~
~~(iii) Repair cast partial framework (D5621, D5622);¶~~
~~(iv) Repair or replace broken retentive/clasping materials - per tooth (D5630);¶~~
~~(v) Add clasp to existing partial denture - per tooth (D5660).¶~~
~~(g) Replace all teeth and acrylic on cast metal framework (D5670, D5671):¶~~
~~(A) Is covered for clients age 16 and older a maximum of once every ten (10) years, per arch;¶~~
~~(B) Ten years or more shall have passed since the original partial denture was delivered;¶~~
~~(C) Is considered replacement of the partial so a new partial denture may not be reimbursed for another ten years; and¶~~
~~(D) Requires Prior Authorization as it is considered a replacement partial denture.¶~~
~~(h) Denture rebase procedures:¶~~
~~(A) The Division shall cover rebases only if a reline may not adequately solve the problem;¶~~
~~(B) For clients through age 20, the Division limits payment for rebase to once every three years;¶~~
~~(C) For clients age 21 and older:¶~~
~~(i) There shall be Documentation of a current reline that has been done and failed; and¶~~
~~(ii) The Division limits payment for rebase to once every five years.¶~~
~~(D) The Division may make exceptions to this limitation in cases of Acute trauma or catastrophic illness that directly or indirectly affects the dental condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily dental hygiene may not warrant rebasing;¶~~
~~(i) Denture reline procedures:¶~~
~~(A) For clients through age 20, the Division limits payment for reline of complete or partial dentures to once every three years;¶~~
~~(B) For clients age 21 and older, the Division limits payment for reline of complete or partial dentures to once every five years;¶~~
~~(C) The Division may make exceptions to this limitation under the same conditions warranting replacement;¶~~
~~(D) Laboratory relines:¶~~
~~(i) Are not payable prior to six months after placement of an immediate denture;¶~~
~~(ii) For clients through age 20, are limited to once every three years;¶~~
~~(iii) For clients age 21 and older, are limited to once every five years.¶~~
~~(j) Interim partial dentures (also referred to as "flippers"):¶~~
~~(A) Are allowed if the client has one or more anterior teeth missing; and¶~~
~~(B) The Division shall reimburse for replacement of interim partial dentures once every five years but only when Dentally Appropriate.¶~~

(k) Tissue conditioning:¶
(A) Is allowed once per denture unit in conjunction with immediate dentures; and¶
(B) Is allowed once prior to new prosthetic placement.¶
(10) MAXILLOFACIAL PROSTHETIC SERVICES (D5900-D5999):¶
(a) Fluoride gel carrier is limited to those patients whose severity of dental disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The Dental Practitioner shall document failure of those options prior to use of the fluoride gel carrier;¶
(b) All other maxillofacial prosthetics (D5900-D5999) are medical services. Refer to OAR 410-123-1220:¶
(A) Bill for medical maxillofacial prosthetics using the professional (CMS1500, DMAP 505 or 837P) claim format;¶
(B) For clients receiving services through a CCO, PHP, or MCE bill medical maxillofacial prosthetics to the CCO, PHP, or MCE;¶
(C) For clients receiving medical services through FFS, bill the Division.¶
(11) ORAL & MAXILLOFACIAL SURGERY (D7000-D7999): Billing Procedures:¶
(a) Bill on a dental claim form using CDT codes for procedures that are directly related to the teeth and the structures directly supporting teeth;¶
(b) The Medical/Surgical Program is responsible for all dental health procedures performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, roof of mouth). Such procedures shall be billed using ICD-10, HCPCS and CPT billing codes using the professional (CMS1500, DMAP 505 or 837P) claim format;¶
(c) D7285, D7286, D7287, D7288 diagnosis codes are reimbursable for all members;¶
(d) D7990 ancillary code is reimbursable for all members;¶
(e) All ancillary and diagnosis codes must be dentally necessary.¶
(f) Alveoloplasty not in conjunction with extractions are reimbursable for members under age 21, and for pregnant individuals (D7320, D7321).¶
(12) ORTHODONTICS (D8000-D8999):¶
(a) Orthodontia services including for cosmetic purposes are not covered except as in (b) of this rule.¶
(b) The Division covers orthodontia services and extractions to treat craniofacial malocclusions, anomalies, cleft lip or cleft palate with cleft lip, and handicapping malocclusions when all of the following conditions are met:¶
(A) Using condition-treatment pair coding for craniofacial anomalies from the Prioritized List of Health Services;¶
(B) Following all corresponding Prioritized List Guideline Notes for treatment and care found on the Prioritized List treatment line;¶
(C) When treatment began prior to age 21, or surgical corrections for covered conditions were not completed prior to age 21; and¶
(D) The Authority approves the request for fee-for-service coverage.¶
(c) Payment and prior authorization for CCO covered services is made by CCO's pursuant to the terms of their contract with OHA, and the provisions of (a) and (b) if this section. Payment and prior authorization requirements in (c) through (k) of this section are for the "fee for service" program.¶
(d) PA is required for orthodontia treatment;¶
(e) Documentation in the client's record shall include diagnosis, length, and type of treatment;¶
(f) Payment for appliance therapy includes the appliance and all follow-up visits;¶
(g) Orthodontists evaluate orthodontia treatment for cleft palate, cleft lip, or cleft palate with cleft lip, cranial facial abnormalities, and dental-facial impairments as two phases. Stage one is generally the use of an activator (palatal expander), and stage two is generally the placement of fixed appliances (banding). The Division shall reimburse each phase separately;¶
(h) The Division shall pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist shall refund to the Division any unused amount of payment after applying the following formula: Total payment minus $300.00 (for banding) multiplied by the percentage of treatment remaining;¶
(i) The Division shall use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;¶
(j) As long as the orthodontist continues treatment, the Division may not require a refund even though the client may become ineligible for medical assistance sometime during the treatment period;¶
(k) Codes D8010-D8690 - PA required; except no PA required for D8660.¶
(13) ADJUNCTIVE GENERAL AND OTHER SERVICES (D9000-D9999):¶
(a) Fixed partial denture sectioning is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment;¶
(b) Anesthesia:¶

~~(A) Only use general Anesthesia or IV sedation for those clients with concurrent needs: age; physical, medical or mental status; or degree of difficulty of the procedure;¶~~
~~(B) The Division reimburses providers with a current permit to administer general Anesthesia or IV sedation as follows:¶~~
~~(i) D9223 or D9243: For each 15-minute period, up to two and a half hours on the same day of service in a dental office setting, and up to three and a half hours on the same day of service in a hospital setting;¶~~
~~(ii) Each 15-minute period represents a quantity of one. Enter this number in the quantity column.¶~~
~~(C) The Division reimburses administration of Nitrous Oxide per date of service, not by time;¶~~
~~(D) Non-intravenous conscious sedation:¶~~
~~(i) Limited to clients under 13 years of age;¶~~
~~(ii) Limited to four times per year;¶~~
~~(iii) Includes payment for monitoring and Nitrous Oxide; and¶~~
~~(iv) Requires use of multiple agents to receive payment.¶~~
~~(E) Upon request, providers shall submit a copy of their permit to administer Anesthesia, analgesia, and sedation to the Division;¶~~
~~(F) For the purpose of Title XIX and Title XXI, the Division limits payment for code D9630 to those dental medications used during a procedure and is not intended for "take home" medication.¶~~
~~(c) The Division limits reimbursement of house/extended care facility call only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience;¶~~
~~(d) Dental devices/appliances (E0485, E0486):¶~~
~~(A) These may be placed or fabricated by a Dentist or oral-surgeon but are considered a medical service);¶~~
~~(B) Bill the Division, CCO, or the PHP, or MCE for these codes using the professional claim format;¶~~
~~(C) CDT code D9947 shall be billed on a dental claim form. See HERC Guideline Notes 27 and 36 for limitations;¶~~
~~(D) Adjustments for dental sleep apnea appliances (D9948) are considered normal follow-up care within the first 90 days after provision of the device, and is included as a bundled rate with D9947;¶~~
~~(E) Dental sleep apnea repairs (D9949) are covered when necessary to make item serviceable. If the expense for repairs exceeds the estimated expense of purchasing another item, no payment shall be made for the excess;¶~~
~~(F) Dental sleep apnea appliances (D9947) are replaceable at the end of their five year reasonable useful lifetime.¶~~
~~(14) Restorative, Periodontal, and Prosthetic Treatment Limitations:¶~~
~~(a) Documentation shall be included in the client's charts to support the treatment;¶~~
~~(b) Treatments shall be consistent with the prevailing standard of care and may be limited as follows:¶~~
~~(A) When prognosis is unfavorable;¶~~
~~(B) When treatment is impractical;¶~~
~~(C) A lesser cost procedure achieves the same ultimate result; or¶~~
~~(D) The treatment has specific limitations outlined in this rule.¶~~
~~(c) Prosthetic treatment, including porcelain fused to metal crowns and porcelain/ceramic crowns are limited until rampant caries is arrested and a period of adequate dental hygiene and periodontal stability is demonstrated. Periodontal health needs to be stable and supportive of a prosthetic;¶~~
~~(d) Full and/or partial denture replacement. For indications and limitations of coverage and dental appropriateness, the Division may cover reasonable and necessary replacement of dentally appropriate, covered full and/or partial dentures, including those items purchased or in use before the client enrolled with the Division:¶~~
~~(A) Replacement of full and/or partial dentures because of loss due to circumstances beyond the member's control, accident or natural disaster/ situations involving the provision of dentally appropriate items when:¶~~
~~(i) There is a change in the client's condition that warrants a new device;¶~~
~~(ii) The item is not repairable;¶~~
~~(iii) There is coverage for the specific item as identified in chapter 410, division 123;¶~~
~~(iv) Full and partial dentures that the client owns may be replaced in cases of loss due to circumstances beyond the member's control or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster.¶~~
~~(B) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of full and/or partial dentures may not be covered~~e Oregon Health Authority (Authority) offers Medicaid dental/denturist benefits on a Fee-For-Service (FFS) basis. chapter 410, division 123 rules are intended to give FFS providers direction in the delivery of dental services and in the preparation of dental care claims. (For Managed Care Entities (MCE) direction in the delivery of dental services and in the preparation of dental care claims refer to OAR 410-141-3835.) ¶
(2) This rule incorporates the Oregon Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), funded through the stated covered line and including all line items, diagnostic and treatment codes, guideline notes, statements of intent, coding specifications and annotations (refer to OAR 410-141-3830). ¶

(3) Dental services covered by Oregon Health Plan (OHP) can be found by referencing the:¶
(a) OHA FFS Fee Schedule (https://www.oregon.gov/oha/hsd/ohp/pages/fee-schedule.aspx);¶
(b) Funded lines on the Prioritized List as defined in OAR 410-141-3830. (https://www.oregon.gov/oha/hpa/dsi-herc/pages/prioritized -list.aspx);¶
(c) Oregon.Gov Covered Dental Codes list;¶
(d) Approved ancillary codes, listed in OAR 410-123-1620; and¶
(e) Oregon Administrative Rules (OAR), Medicaid covered services, are found throughout chapter 410;¶
(4) All coverage limitations and exclusions are subject to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) (refer to chapter 410, division 151.¶
(5) Diagnostic services (CDT codes D0100 - D0999):¶
(a) Dental screenings (D0190) including state or federally mandated screenings, are limited observations performed as mass screenings or EPSDT well-child and preventative care visits, to identify individuals who have suspected oral health needs and who must be seen by a dentist for diagnosis. Reimbursement is for providers who hold a certificate of completion from Smiles for Life or First Tooth;¶
(b) Dental assessments (D0191) are limited clinical inspections performed to identify possible signs of oral systemic disease, malformation, or injury, and the potential need for referral diagnosis and treatment. Reimbursement is for licensed or certified dental professionals whose scope of practice includes assessing oral health or Physicians (MD or DO), advance practice nurses, or licensed physician assistants who hold a certificate of completion from Smiles for Life or First Tooth.¶
(c) The assessment tool used for D0190 and D0191 must be endorsed by the American Dental Association, the American Academy of Pediatric Dentistry, the Association of State and Territorial Dental Directors, or the American Academy of Pediatrics.¶
(A) Referrals for identified dental needs or for the establishment of a dental home are to be made to the member's primary care dentist for FFS members, or to the member's CCO;¶
(B) Anticipatory guidance and counseling on good dental hygiene practices and nutrition is to be provided to the member's caregiver;¶
(C) Risk assessment findings and service components provided are to be documented in the medical chart;¶
(D) Reimbursable only if an exam (D0120-D0180) is not performed on the same date of service. Assessment of a Patient (D0191) is included as part of an exam (D0120-D0180);¶
(E) For EPSDT beneficiaries, a maximum of twice (2) every twelve (12) months (refer to chapter 410, division 151); and¶
(F) For non-EPSDT beneficiaries, a maximum of once (1) every twelve (12) months.¶
(G) An assessment does not take the place of the need for dental evaluations/exams.¶
(d) Referrals:¶
(A) If, during the screening process (periodic or inter-periodic), a dental, medical, substance abuse, or medical condition is discovered, the member must be referred to an appropriate provider for further diagnosis and/or treatment;¶
(B) The screening provider must explain the need for the referral to the member, member's parent, or guardian;¶
(C) If the member, member's parent, or guardian agrees to the referral, assistance in finding an appropriate provider and making an appointment shall be offered;¶
(D) The member's FFS provider or the MCE program shall make available care coordination as needed.¶
(e) Clinical Dental evaluations (Exams) for:¶
(A) EPSDT beneficiaries (refer to OAR 410-200-0455):¶
(i) The Authority covers exams (D0120, D0145, D0150, or D0180) a maximum of twice (2) every twelve (12) months with the following limitations:¶
(I) D0150: once (1) every twelve (12) months when performed by the same practitioner;¶
(II) D0180: once (1) every twelve (12) months.¶
(ii) The Authority must reimburse D0160 only once (1) every twelve (12) months when performed by the same practitioner.¶
(B) For non-EPSDT beneficiaries, the Authority must reimburse exams (billed as CDT codes D0120, D0150, D0160, or D0180) once (1) every twelve (12) months;¶
(C) For problem focused exams (urgent or emergent problems), the Authority must reimburse D0140 for the initial exam. The Authority must reimburse D0170 for related problem-focused follow-up exams. Providers must not bill D0140 and D0170 for routine dental visits;¶
(D) The Authority only covers dental exams performed by medical practitioners when the medical practitioner is an oral surgeon. The surgeon may hold a dual degree, but must bill as an oral surgeon;¶
(E) As the American Dental Association's (ADA's) Current Dental Terminology (CDT) codebook specifies, the evaluation, diagnosis, and treatment planning components of the exam are the responsibility of the licensed provider. The Authority may not reimburse dental exams when performed by a dental hygienist (with or without

an expanded practice permit).¶
(f) Diagnostic imaging:¶
(A) The Authority covers routine imaging once (1) every twelve (12) months;¶
(B) The Authority covers bitewing radiographs for routine screening once (1) every twelve (12) months;¶
(i) D0240, D0250, D0251, D0273, D0274, D0277, D0321, D0322, D0701 - D0709 are reimbursed once (1) every twelve (12) months for all members;¶
(ii) D0210, D0330 are reimbursed once (1) every five (5) years, unless D0210 has been billed within the five (5) year period.¶
(C) The Authority covers a maximum of six (6) images for any one (1) emergency;¶
(D) For members under age six (6), images may be billed separately every twelve (12) months as follows:¶
(i) D0220 - once (1);¶
(ii) D0230 - a maximum of five (5) times;¶
(iii) D0270 - a maximum of twice (2), or D0272 once (1).¶
(E) The Authority covers panoramic radiographic image or intra-dental complete series once (1) every five (5) years, but both cannot be done within the five (5) year period;¶
(F) Members must be a minimum of six (6) years old for billing intra-dental complete series. The minimum standards for reimbursement of intra-dental complete series are:¶
(i) For members age six (6) through eleven (11) a minimum of ten (10) periapical and two (2) bitewings for a total of twelve (12) films;¶
(ii) For members ages twelve (12) and older a minimum of ten (10) periapical and four (4) bitewings for a total of fourteen (14) films.¶
(G) If fees for multiple single radiographs exceed the allowable reimbursement for an intraoral-complete series (full mouth), the Authority must reimburse for the complete series;¶
(H) Additional films are covered if dentally necessary and medically appropriate, e.g., fractures);¶
(I) If the Authority determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area shall be denied;¶
(J) The exception to these limitations is if the member is new to the office or clinic and the office or clinic is unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records must be included in the member's records;¶
(K) Digital radiographs, if printed, must be on photo paper to assure sufficient quality of images.¶
(6) Preventative Services (CDT codes D1000-D1999):¶
(a) Topical fluoride treatment:¶
(A) For EPSDT beneficiaries, limited to twice (2) every twelve (12) months;¶
(B) For non-EPSDT beneficiaries, limited to once (1) every twelve (12) months;¶
(C) Additional topical fluoride treatments are available, up to a total of four (4) treatments per member within a twelve (12) month period, when high-risk conditions or dental health factors are clearly documented in chart notes for members who:¶
(i) Have high-risk dental conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;¶
(ii) Are pregnant;¶
(iii) Have physical disabilities and cannot perform adequate, daily dental health care;¶
(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily dental health care; or¶
(v) Are under seven (7) years old with high-risk dental health factors, such as poor dental hygiene, deep pits, and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.¶
(D) Fluoride limits include any combination of fluoride varnish or other topical fluoride.¶
(b) Sealants:¶
(A) Are covered only for children under sixteen (16) years of age;¶
(B) The Authority limits coverage to:¶
(i) Permanent molars; and¶
(ii) Only one (1) sealant treatment per molar every five (5) years, except for visible evidence of clinical failure.¶
(c) Dental prophylaxis:¶
(A) EPSDT beneficiaries, limited to twice (2) per twelve (12) months;¶
(B) Non-EPSDT beneficiaries, limited to once (1) per twelve (12) months; and¶
(C) Additional prophylaxis benefit provisions are available for persons with high-risk dental conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily dental health care.¶
(d) Interim caries arresting medicament application (D1354, D1355): When used to represent silver diamine fluoride (SDF) applications for the treatment (rather than prevention) of caries, is limited to:¶

(A) Two (2) applications per year;¶
(B) Requires that the tooth or teeth numbers be included on the claim;¶
(C) Must be covered with topical application of fluoride when performed on the same date of service when treating a carious lesion;¶
(D) Must be covered with an interim therapeutic restoration (D2941) or a permanent restoration and (D1354, D1355) on the same tooth, when medically necessary and dentally appropriate.¶
(e) Interim caries arresting medicament application (D1354) is also included on the Prioritized List to arrest or reverse non-cavitated carious lesions. See Prioritized List Guideline Note 91 for more detail.¶
(f) Tobacco cessation:¶
(A) For services provided during a dental visit, bill as a dental service using D1320 when the following 5 step counseling is provided:¶
(i) ASK: Identify the member's tobacco-use status at each visit and record information in the chart;¶
(ii) ADVISE: Using a strong personalized message, advise members on their dental health conditions related to tobacco use and give direct advice to quit using tobacco and seek help;¶
(iii) ASSESS: Refer member to external resources or internal counseling and intervention protocol if the tobacco user is willing to make a quit attempt;¶
(iv) ASSIST: Provide counseling and pharmacotherapy to help member quit tobacco, if dental provider chooses to assist; and¶
(v) ARRANGE: Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date if dental provider chooses to arrange.¶
(B) The Authority covers a maximum of ten (10) services within a three (3) month period.¶
(e) Space maintenance (passive appliances) are:¶
(A) Covered for EPSDT beneficiaries;¶
(B) Not replaceable when lost or damaged.¶
(7) Restorative Services (CDT codes D2000-D2999):¶
(a) Amalgam and resin-based composite restorations, direct:¶
(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for EPSDT beneficiaries, and members who are pregnant;¶
(B) The Authority reimburses posterior composite restorations at the same rate as amalgam restorations;¶
(C) The Authority limits payment of posterior composite restorations to once (1) every five (5) years, per tooth;¶
(D) The Authority limits payment of covered restorations to the maximum restoration fee of four (4) surfaces per tooth. Refer to the ADA CDT codebook for definitions of restorative procedures;¶
(E) Providers must combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces);¶
(F) The Authority shall not reimburse for an amalgam or composite restoration and a crown on the same tooth;¶
(G) Interim therapeutic restoration on primary dentition is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration;¶
(H) Reattachment of tooth fragment is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment;¶
(I) The Authority reimburses for a surface not more than once (1) in each treatment episode regardless of the number or combination of restorations;¶
(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration.¶
(b) Indirect crowns and related services:¶
(A) General payment policies:¶
(i) The fee for the crown includes payment for preparation of the gingival tissue;¶
(ii) The Authority covers crowns only when:¶
(I) There is significant loss of clinical crown, and no other restorations restore function; and¶
(II) The crown-to-root ratio is 50:50 or better, and the tooth is restorable without other surgical procedures.¶
(iii) The Authority covers core buildup only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50 percent of the tooth structure must be remaining for coverage of the core buildup;¶
(iv) Reimbursement of retention pins is per tooth, not per pin.¶
(B) The Authority does not cover the following services:¶
(i) Endodontic therapy alone (with or without a post);¶
(ii) Aesthetics (cosmetics);¶
(iii) Crowns in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason.¶
(C) Prefabricated stainless steel crowns are allowed only for anterior primary teeth and posterior permanent or

primary teeth;¶
(D) The Authority covers the following only for EPSDT beneficiaries, and for members who are pregnant:¶
(i) Prefabricated resin crowns for anterior teeth, permanent or primary;¶
(ii) Prefabricated resin crowns for posterior teeth, permanent or primary, once (1) per tooth in a five (5) year period;¶
(iii) Prefabricated stainless-steel crowns with resin window are allowed only for anterior teeth, permanent or primary;¶
(iv) Prefabricated post and core in addition to crowns;¶
(v) Crowns (resin-based composite - D2710 and D2712, porcelain fused to metal (PFM) - D2751 and D2752), and porcelain ceramic - D2740 as follows:¶
(I) Limited to teeth numbers 6-11, 22, and 27 only, if dentally appropriate;¶
(II) Limited to four (4) in a seven (7) year period. This limitation includes any replacement crowns allowed; and¶
(III) Rampant caries are arrested, and the member demonstrates a period of dental hygiene before prosthetics are proposed.¶
(vi) Porcelain fused to metal crowns (D2751, D2752), and porcelain ceramic crowns (D2740) must meet the following additional criteria:¶
(I) The Dental Practitioner has attempted all other dentally appropriate restoration options and documented failure of those options;¶
(II) Written documentation in the member's chart indicates that PFM is the only restoration option that restores function;¶
(III) The Dental Practitioner submits radiographs to the Authority for review. History, diagnosis, and treatment plan may be requested;¶
(IV) The member has documented stable periodontal status with pocket depths within 1-3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeters and over, documentation must be maintained in the member's chart of the dentist's findings supporting stability and why the increased pocket depths shall not adversely affect expected long-term prognosis;¶
(V) The crown has a favorable long-term prognosis; and¶
(VI) If the tooth to be crowned is a clasp/abutment tooth in partial denture, both prognosis for the crown itself and the tooth's contribution to partial denture must have favorable expected long-term prognosis.¶
(E) Crown replacement coverage is as follows:¶
(i) D2710, D2712, D2740, D2751, D2752 are limited to once (1) every seven (7) years;¶
(ii) All other covered crowns are limited to once (1) every five (5) years; and¶
(iii) Exceptions to the above limitations due to acute trauma are based on the following factors:¶
(I) Extent of crown damage;¶
(II) Extent of damage to other teeth or crowns;¶
(III) Extent of impaired mastication;¶
(IV) Tooth is restorable without other surgical procedures; and¶
(V) If loss of tooth may result in coverage of removable prosthetic.¶
(F) Crown repair is limited to only anterior teeth.¶
(8) Endodontic Services (CDT codes D3000-D3999):¶
(a) Endodontic therapy:¶
(A) All primary teeth are covered for EPSDT beneficiaries;¶
(B) Permanent teeth:¶
(i) Anterior and bicuspid teeth are covered for all members; and¶
(ii) Molars are covered as follows:¶
(I) EPSDT beneficiaries, first and second molars; and¶
(II) Members who are pregnant, only first molars.¶
(C) The Authority covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures.¶
(b) Endodontic retreatment and apicoectomy:¶
(A) The Authority does not cover retreatment of a previous root canal or apicoectomy for bicuspid teeth or molars;¶
(B) The Authority limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:¶
(i) Crown-to-root ratio is 50:50 or better;¶
(ii) The tooth is restorable without other surgical procedures; or¶
(iii) If loss of tooth shall result in the need for removable prosthodontics.¶
(C) Retrograde filling is covered only when done in conjunction with a covered apicoectomy of an anterior tooth.¶
(c) The Authority does not allow separate reimbursement for open-and-drain as a palliative procedure when the

root canal is completed on the same date of service or if the same practitioner or Dental Practitioner in the same group practice completed the procedure;¶
(d) The Authority covers endodontics if the tooth is restorable.¶
(e) Apexification/recalcification procedures:¶
(A) The Authority limits payment for apexification to a maximum of five (5) treatments on permanent teeth only;¶
(B) Covered only for EPSDT beneficiaries, or members who are pregnant.¶
(9) Periodontic Services (CDT codes D4000-D4999):¶
(a) Surgical periodontal services:¶
(A) Gingivectomy/Gingivoplasty limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to dental hygiene procedures, e.g., Dilantin hyperplasia;¶
(B) Includes six (6) months routine postoperative care; and¶
(C) The Authority considers gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) as part of the restoration and does not provide a separate reimbursement for this procedure.¶
(b) Non-surgical periodontal services:¶
(A) Periodontal scaling and root planing:¶
(i) Allowed once (1) every two (2) years;¶
(ii) A maximum of two (2) quadrants on one date of service is payable, except in extraordinary circumstances supported by documentation;¶
(iii) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets of 5 mm or greater:¶
(I) D4341 is allowed for quadrants with at least four (4) or more teeth with pockets of 5 mm or greater. Single implants may now be covered by counting the implant as an additional tooth when billing D4341. The maximum number per quadrant and pocket depth requirements still apply; or¶
(II) D4342 is allowed for quadrants with at least two (2) teeth with pocket depths of 5 mm or greater. Single implants may now be covered by counting the implant as an additional tooth when billing D4342. The maximum number per quadrant and pocket depth requirements still apply.¶
(B) Full mouth debridement allowed only once (1) every two (2) years;¶
(C) Scaling in the presence of generalized moderate or severe gingival inflammation, full mouth, after dental evaluation, allowed only once (1) every two (2) years.¶
(c) Periodontal maintenance allowed once (1) every six (6) months:¶
(A) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three (3) years;¶
(B) Additional periodontal maintenance requires PA and may be requested when:¶
(i) Medically necessary and dentally appropriate, such as due to presence of periodontal disease during pregnancy; and¶
(ii) Member's medical record is submitted that supports the need for increased periodontal maintenance (chart notes, pocket depths and radiographs).¶
(d) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and radiographs;¶
(e) The Authority does not reimburse for procedures identified by the following codes if performed on the same date of service:¶
(A) D1110 (Prophylaxis - adult);¶
(B) D1120 (Prophylaxis - child);¶
(C) D4210 (Gingivectomy or gingivoplasty - four (4) or more contiguous teeth or bounded teeth spaces per quadrant);¶
(D) D4211 (Gingivectomy or gingivoplasty, one (1) to three (3) contiguous teeth or bounded teeth spaces per quadrant);¶
(E) D4341 (Periodontal scaling and root planing, four (4) or more teeth per quadrant);¶
(F) D4342 (Periodontal scaling and root planing, one (1) to three (3) teeth per quadrant);¶
(G) D4346 (Scaling in presence of generalized moderate to severe inflammation, full mouth after dental evaluation);¶
(H) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and¶
(I) D4910 (Periodontal maintenance).¶
(10) Prosthodontics, Removable (CDT codes D5000-D5899):¶
(a) If a dentist or denturist provides an eligible member with fabricated prosthetics that require the use of a dental laboratory, the date of the final impressions must have occurred prior to the member's loss of coverage;¶
(b) The dentist or denturist shall use the date of final impression as the date of service only when criteria in (a) is met and the fabrication extends beyond the member's OHP coverage;¶
(c) The date of delivery must be within 45 days of the date of the final impression and the date of delivery must

also be indicated on the claim. All other services must be billed using the date the service was provided.¶
(d) The fee for the partial and complete dentures includes payment for adjustments during the six (6) month period following delivery to members;¶
(e) Resin partial dentures:¶
(A) The Authority does not approve resin partial dentures if stainless steel crowns are used as abutments;¶
(B) For EPSDT beneficiaries, the member must have one (1) or more anterior teeth missing or four (4) or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;¶
(C) For non-EPSDT beneficiaries, the member must have one (1) or more missing anterior teeth or six (6) or more missing posterior teeth per arch with documentation by the provider of resulting space causing serious impairment to mastication. Third molars are not a consideration when counting missing teeth;¶
(D) The Practitioner must note the teeth to be replaced and teeth to be clasped when requesting Prior Authorization (PA).¶
(f) Replacement of removable partial or complete dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:¶
(A) Complete dentures once (1) every ten (10) years, only if medically necessary and dentally appropriate;¶
(B) Partial dentures once (1) every five (5) years, only if medically necessary and dentally appropriate.¶
(C) The five (5) and ten (10) year limitations apply to the member regardless of the member's OHP or MCE enrollment status at the time the member's last denture or partial was received.;¶
(D) Replacement of partial dentures with complete dentures is payable five (5) years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma, natural disaster, or catastrophic illness that directly or indirectly affects the dental condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for the conditions mentioned earlier. Severe periodontal disease due to neglect of daily dental hygiene may not warrant replacement.¶
(g) The Authority limits reimbursement of adjustments and repairs of dentures that are needed beyond six (6) months after delivery of the denture as follows:¶
(A) A maximum of four (4) times per year for:¶
(i) Adjustments to dentures, per arch - complete and partial (D5410 - D5422);¶
(ii) Replace missing or broken teeth - complete denture, each tooth (D5520);¶
(iii) Replace broken tooth on a partial denture - each tooth (D5640);¶
(iv) Add tooth to existing partial denture (D5650).¶
(B) A maximum of two (2) times per year for:¶
(i) Repair broken complete denture base (D5511, D5512);¶
(ii) Repair resin partial denture base (D5611, D5612);¶
(iii) Repair cast partial framework (D5621, D5622);¶
(iv) Repair or replace broken retentive/clasping materials - per tooth (D5630);¶
(v) Add clasp to existing partial denture - per tooth (D5660).¶
(h) Replacement of all teeth and acrylic on cast metal framework (D5670, D5671) is covered with a PA:¶
(A) A maximum of once (1) every ten (10) years, per arch;¶
(B) When ten (10) or more years have passed since the original partial denture was delivered; and¶
(C) And is considered replacement of the partial so a new partial denture shall not be reimbursed for another ten (10) years.¶
(i) Denture rebase procedures:¶
(A) The Authority covers rebases only if a reline does not adequately solve the problem;¶
(B) For EPSDT members, the Authority covers rebase once (1) every three (3) years;¶
(C) For non-EPSDT members:¶
(i) There must be documentation of a current reline that has been done and failed; and¶
(ii) The Authority limits payment for rebase to once (1) every five (5) years.¶
(D) The Authority may make exceptions to this limitation in cases of acute trauma or catastrophic illness that directly or indirectly affects the dental condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment of these conditions. Severe periodontal disease due to neglect of daily dental hygiene may not warrant rebasing;¶
(j) Denture reline procedures:¶
(A) For EPSDT members, the Authority covers reline of complete or partial dentures once (1) every three (3) years;¶
(B) For non-EPSDT members, the Authority limits payment for reline of complete or partial dentures to once (1) every five (5) years;¶
(C) The Authority may make exceptions to this limitation under the same conditions warranting replacement;¶

(D) Laboratory relines:¶
(i) Are not payable prior to six (6) months after placement of an immediate denture;¶
(ii) For EPSDT members, the Authority limits payment to once (1) every three (3) years;¶
(iii) For non-EPSDT members, the Authority limits payment to once (1) every five (5) years.¶
(k) Interim partial dentures (also referred to as "flippers"):¶
(A) Are allowed if the member has one (1) or more anterior teeth missing; and¶
(B) The Authority must reimburse for replacement of interim partial dentures once (1) every five (5) years but only when medically necessary and dentally appropriate.¶
(l) Tissue conditioning:¶
(A) Is allowed once per denture unit in conjunction with immediate dentures; and¶
(B) Is allowed once prior to new prosthetic placement.¶
(11) Maxillofacial Prosthetic Services (CDT codes D5900-D5999):¶
(a) Fluoride gel carrier is limited to those members whose severity of dental disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The Dental Practitioner must document failure of those options prior to use of the fluoride gel carrier; and¶
(b) All other maxillofacial prosthetics are medical services;¶
(A) Bill for medical maxillofacial prosthetics using the professional (CMS1500, DMAP 505, 837D or 837P) claim format;¶
(B) For members receiving services through an MCE bill medical maxillofacial prosthetics to the MCE; and¶
(C) For members receiving medical services through FFS, bill the Authority.¶
(12) Prosthodontics, fixed (CDT codes D6200-D6999) - D6100 and D6105 are only covered when there is advanced peri-implantitis with bone loss and mobility, abscess or implant fracture.¶
(13) Oral & Maxillofacial Surgery (D7000-D7999): Billing Procedures:¶
(a) Bill on a dental claim form using CDT codes for procedures that are directly related to the teeth and the structures directly supporting teeth;¶
(b) The Medical/Surgical Program is responsible for all dental health procedures performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, roof of mouth). Such procedures must be billed using ICD-10, HCPCS and CPT billing codes using the professional (CMS1500, DMAP 505 or 837P) claim format;¶
(c) The following services are covered based on severity and included situations deemed to cause gingival recession or movement of the gingival margin when frenum is placed under tension:¶
(A) Buccal/labial frenectomy (frenulectomy) (D7961)¶
(B) Lingual frenectomy (frenulectomy) (D7962)¶
(C) Frenuloplasty (D7963)¶
(d) Emergency tracheotomy (D7990) is an ancillary code reimbursable for all members;¶
(e) All ancillary and diagnosis codes must be used for services that are medically necessary and dentally appropriate.¶
(f) Alveoloplasty not in conjunction with extractions are reimbursable for EPSDT beneficiaries, and for members who are pregnant. (D7320, D7321).¶
(14) Orthodontics (CDT Codes D8000-D8999):¶
(a) The Authority covers orthodontia services to treat cleft palate with airway obstruction, cleft palate and/or cleft lip, or deformities of the head, and handicapping malocclusions (HM), not for cosmetic purposes, when:¶
(A) The member has a craniofacial anomaly health condition that is included on a covered line of the Prioritized List of Health Services; and¶
(B) The Authority approves the PA request for orthodontic treatment.¶
(b) Pre-orthodontic treatment examinations (D8660) must be provided by a licensed dentist.¶
(c) Pre-orthodontic treatment examinations (D8660) are covered only for members whose clinical presentation and preliminary findings strongly suggest that they may qualify for orthodontic treatment under HM criteria, as established by the Authority. Reimbursement does not require PA, and is allowable:¶
(A) Once (1) per member, per provider, in a twelve (12) month period (not on the same day as another routine or general dental evaluation or examination); and¶
(B) When submitted alongside the following documentation to justify the need for treatment:¶
(i) The Authority-approved Handicapping Labiolingual Deviation (HLD) Index California Modified Scoring Form (completed, scored, and signed);¶
(ii) Intra-oral and extra-oral photographs of diagnostic quality, adhering to American Association of Orthodontists (AAO) standards, capturing key aspects of the malocclusion;¶
(iii) Panoramic radiographs and cephalometric images including tracings that document skeletal and dental relationships crucial for evaluating the severity of malocclusion; and¶
(iv) A comprehensive narrative of medical necessity, explicitly stating how the malocclusion significantly impacts

the member's oral health, airway, or overall functional capacity.¶
(d) PA approval for comprehensive orthodontic treatment (D8070, D8080, D8090), must meet the criteria in Guideline Note 169 of the Prioritized List of Health Service.¶
(e) Comprehensive orthodontic treatment must be completed by a licensed dentist who has:¶
(A) Completed a Commission of Dental Accreditation (CODA) orthodontic fellowship or residency program;¶
(B) Certified additional orthodontic training, a minimum of thirty (30) hours of orthodontic continuing education (CE) in the past three (3) years that was approved by the American Dental Association Continuing Education Recognition Program (ADA CERP); or¶
(C) Completed five (5) comprehensive orthodontic treatment cases in the past three (3) years, verified by case logs and patient outcomes.¶
(f) Orthodontic treatment must begin while the member is an EPSDT beneficiary, or immediately after, if surgical corrections that were started during the member's EPSDT beneficiary period for covered conditions were not completed during that period.¶
(g) For auditing purposes, refer to OAR 410-120-1396. ¶
(h) Payment for comprehensive orthodontic treatment includes all appliances and all follow-up visits.¶
(i) The Authority pays for orthodontia in one lump sum upon beginning of treatment;¶
(A) If the member transfers to another orthodontist during treatment, or treatment is terminated, the Authority shall recover the overpayment (refer to OAR 410-120-1397) based on the length of the treatment plan from the first date of service (DOS); and ¶
(B) Providers may discontinue orthodontic treatment of a member in cases including poor dental hygiene, continued missed appointments, or if treatment is a detriment to the member.¶
(j) Licensed dentists providing orthodontic treatment may:¶
(A) Submit PA requests for the extractions and/or bond surgeries that are documented as needed in the member's orthodontic treatment plan; and¶
(B) Refer members to enrolled specialists for extractions and/or bond surgeries when such services are beyond the scope of the member's primary care dentist. ¶
(k) As long as the orthodontist continues treatment, the Authority may not require a refund even though the member may become ineligible for medical assistance sometime during the treatment period.¶
(l) Care navigation assistance for members must be made available during transfer of care in situations such as provider changes.¶
(15) Adjunctive General and Other Services (CDT codes D9000-D9999):¶
(a) Fixed partial denture sectioning is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment;¶
(b) Anesthesia:¶
(A) The Authority reimburses administration of general anesthesia or IV sedation only for those members with concurrent needs: age; physical, medical, or mental status; or degree of difficulty of the procedure; and¶
(B) The Authority reimburses providers with a current permit to administer General Anesthesia or IV Sedation as follows:¶
(i) For each 15-minute period, up to two and a half hours on the same day of service in a dental office setting, and up to three and a half hours on the same day of service in a hospital setting;¶
(ii) Each 15-minute period represents a quantity of one. Enter this number in the quantity column.¶
(C) The Authority reimburses administration of Nitrous Oxide per date of service, not by time;¶
(D) Non-intravenous conscious sedation:¶
(i) Limited to members under 13 years of age;¶
(ii) Limited to four (4) times per year;¶
(iii) Includes payment for monitoring and Nitrous Oxide; and¶
(iv) Requires use of multiple agents to receive payment.¶
(E) Upon request, providers must submit a copy of their permit to administer Anesthesia, Analgesia, and Sedation to the Authority; and¶
(F) For the purpose of Title XIX and Title XXI, the Authority limits payment for code D9630 to those dental medications used during a procedure and is not intended for "take home" medication.¶
(c) The Authority limits reimbursement of house/extended care facility calls only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience.¶
(16) Sleep Apnea Services:¶
(a) These devices and appliances may be placed or fabricated by a dentist or oral surgeon but are considered a medical service;¶
(b) Bill the Authority or MCE for these codes using the professional claim format;¶

(c) Custom sleep apnea appliance fabrication and placement (D9947) must be billed on a dental claim form (See HERC Guideline Notes 27 and 36 for limitations), and is replaceable at the end of the five (5) year reasonable useful lifetime;¶
(d) Adjustments for dental sleep apnea appliances (D9948) are considered normal follow-up care within the first ninety (90) days after provision of the device, and is included as a bundled rate with D9947; and¶
(e) Dental sleep apnea repairs (D9949) are covered when necessary and appropriate to make item serviceable. If the expense for repairs exceeds the estimated expense of purchasing another item, no payment must be made for the excess.¶
(17) Restorative, Periodontal, and Prosthetic Treatment Limitations:¶
(a) Documentation must be included in the member's charts to support the treatment;¶
(b) Treatments must be consistent with the prevailing standard of care and may be limited as follows, when:¶
(A) Prognosis is unfavorable;¶
(B) Treatment is impractical;¶
(C) A lesser cost procedure achieves the same ultimate result; or¶
(D) The treatment has specific limitations outlined in this rule.¶
(c) Prosthetic treatment, including porcelain fused to metal crowns and porcelain/ceramic crowns are limited until rampant caries is arrested and a period of adequate dental hygiene and periodontal stability is demonstrated. Periodontal health needs to be stable and supportive of a prosthetic;¶
(d) Complete and/or partial denture replacement. For indications and limitations of coverage and dental appropriateness, the Authority may cover reasonable and necessary replacement of medically necessary and dentally appropriate, covered complete and/or partial dentures, including those items purchased or in use before the member enrolled with the OHP:¶
(A) Replacement of complete and/or partial dentures because of loss due to circumstances beyond the member's control, accident or natural disaster/ situations involving the provision of medically necessary and dentally appropriate items when:¶
(i) There is a change in the member's condition that warrants a new device;¶
(ii) The item is not repairable;¶
(iii) There is coverage for the specific item as identified in chapter 410, division 123;¶
(iv) Complete and partial dentures that the member owns may be replaced in cases of loss due to circumstances beyond the member's control or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster.¶
(B) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of complete or partial dentures may not be covered.¶
(18) Dental care access standards for pregnant members with FFS:¶
(a) Pregnant members must be seen, treated in person or via teledentistry for the following OHP-covered services and within the time frames as followed:¶
(A) Emergency dental care: within 24 hours (seen or treated);¶
(B) Urgent dental care: within one (1) week.¶
(C) Routine dental care: within four (4) weeks, unless there is a documented special clinical reason that may make it appropriate to see the member beyond this timeframe;¶
(D) Initial dental screening or examination: four (4) weeks.¶
(b) Additional Dental Services are available to pregnant members if authorized as medically necessary and dentally appropriate, and include:¶
(A) Additional prophylaxis, fluoride, and periodontal services;¶
(B) Permanent crowns and resin-based composite crowns for anterior teeth;¶
(C) Prefabricated post and core;¶
(D) Root canals on first molars;¶
(E) Apexification/recalcification, pulpal regeneration; and¶
(F) Alveoplasty not in conjunction with extractions.¶
(c) Nothing obligates a pregnant FFS member to accept an offered appointment; and¶
(d) Dental care benefits for pregnant members shall continue for twelve (12) months following the end of pregnancy.¶
(19) Services considered incidental, integral to the primary service rendered, part of another service, or included in routine post-op or follow-up care are not eligible for separate reimbursement.¶
(a) Participating providers may not balance bill members for these services;¶
(b) Services that are not to be billed separately may be included in the Current Dental Terminology (CDT) codebook; ¶
(c) May not be listed as combined with another procedure; and¶
(d) For CMS Medicare Dental Coverage information https://www.cms.gov/medicare/coverage/dental.¶

(20) The following services are not eligible for separate reimbursement:¶
(a) Alveolectomy/Alveoloplasty in conjunction with extractions;¶
(b) Cardiac and other monitoring;¶
(c) Caries risk assessment and documentation;¶
(d) Curettage and root planing - per tooth is not eligible for separate reimbursement unless the service is significant and separately identifiable;¶
(e) Diagnostic casts;¶
(f) Dietary counseling;¶
(g) Direct pulp cap;¶
(h) Discing;¶
(i) Dressing change;¶
(j) Electrosurgery;¶
(k) Equilibration;¶
(L) Gingival curettage - per tooth;¶
(m) Gingival irrigation;¶
(n) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth;¶
(o) Indirect pulp cap;¶
(p) Local anesthesia;¶
(q) Medicated pulp chambers;¶
(r) Occlusal adjustments;¶
(s) Occlusal analysis;¶
(t) Odontoplasty;¶
(u) Oral hygiene instruction;¶
(v) Periodontal charting, probing;¶
(w) Post removal;¶
(x) Polishing fillings;¶
(y) Post extraction treatment for alveolaritis (dry socket treatment) if done by the provider of the extraction;¶
(z) Pulp vitality tests;¶
(aa) Smooth broken tooth;¶
(bb) Special infection control procedures;¶
(cc) Surgical procedure for isolation of tooth with rubber dam;¶
(dd) Surgical splint;¶
(ee) Surgical stent; and¶
(ff) Suture removal.¶
(21) The following general categories of dental services are not covered for any member, unless coverage is specified or member is an EPSDT beneficiary and meets requirements of OAR chapter 410, division 151, as several of these services are considered elective or "cosmetic" in nature (i.e., done for the sake of appearance):¶
(a) Desensitization;¶
(b) Implant and implant services (See Prioritized List Guideline Notes 123 and 169);¶
(c) Mastique or veneer procedure;¶
(d) Orthodontic treatment (except for cleft palate with airway obstruction, cleft palate and/or cleft lip, or deformities of head and handicapping malocclusion meeting criteria and PA requirements);¶
(e) Overhang removal;¶
(f) Procedures, appliances, or restorations solely for aesthetic or cosmetic purposes;¶
(g) Temporomandibular joint (TMJ) dysfunction treatment; and¶
(h) Tooth bleaching.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1262

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be Amended: This section provides guidance for Dental administration of vaccines for the Dental/Denturis

CHANGES TO RULE:

410-123-1262
Dental Administration of Vaccines
(1) Dental administration of vaccines ~~shall~~must be carried out in compliance with Oregon Board of Dentistry OARs 818-01
Medical/Surgical OAR 410-130-0255 and Vaccines for Children (VFC) - OHA Division 46, OARs 333-046-0110 through 33
(2) Requirements for vaccine administration:¶
(a) The ~~dentist shall~~licensed provider must have completed a course of training approved by the Oregon Board of Dentistry
(b) Vaccines ~~shall~~must be administered in accordance with the Model ~~Standing Order~~Immunization Protocols approved by
(c) The dentist ~~shall~~must not delegate administration of vaccines to another person.¶
(3) Procedures for ~~vaccine administration.¶~~
~~(a) Dentists shall:~~licensed providers administering vaccines:¶
(a) Must report to ALERT within fourteen (14) days of administration;¶
(A) Follow the Authority approved Model ~~Standing Order~~Immunization Protocols for immunization administration and trea
following an administration. The Authority Model ~~Standing order~~Immunization Protocols are located at:
https://www.oregon.gov/oha/PH/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Pages/pr
Administration section);¶
(B) Maintain written policies and procedures for handling and disposal of used or contaminated equipment and supplies;¶
(C) If providing state or federal vaccines, report the vaccine eligibility code as specified by the Authority, to the ALERT ~~S~~sys
https://www.oregon.gov/oha/PH/PreventionWellness/VaccinesImmunization/alert/Pages/EnrollNewClinic.aspx;¶
(~~D~~b) ~~As administrator of the vaccine, report to the Authority the information in section 6(a)(A), (B) and (C) of this rule as app~~
~~Immunization System~~Report adverse events within ~~fourte~~ten (140) ~~days of administration;¶~~
~~(E) Report adverse events, as required by the~~business days to the:¶
(A) Vaccine Adverse Events Reporting System (VAERS) ~~to the~~;¶
(B) Oregon Board of Dentistry~~, within ten (10) business days;¶~~
~~(F) Within ten (10) days to the p~~; and¶
(C) Primary ~~c~~Care ~~p~~Provider (PCP) identified by the ~~patient; and¶~~
~~(G)~~member. If the ~~patient~~member does not have a PCP, providers ~~shall~~must:¶
(i) Provide the ~~patient~~member with a copy of vaccination administration ~~D~~documentation;¶
(ii) Direct the member toward resources containing more information;¶
(iii) Encourage the member to become a physician's patient of record for their other health needs; and¶
(iv) Document actions in the ~~patient~~member's record.¶
(~~b~~c) Dentists or designated staff ~~shall~~must:¶
(A) Provide Vaccine Information Statements (VIS) to the ~~patient~~member or legal representative with each dose of vaccine c
(B) Document that the ~~patient~~member or legal representative has read, or has had read to them, the information provided a
prior to the administration of the vaccine. The VIS provided ~~shall~~must be the most current version; and¶
(C) Document in the ~~patient~~member record:¶
(i) Date;¶
(ii) Site of administration;¶
(iii) Brand name or NDC number or other acceptable standardized vaccine code set;¶
(iv) Dose, manufacturer, lot # (number), and expiration date of vaccine;¶
(v) Name and identifiable initials of administering dentist;¶
(vi) Address of office where vaccine was administered, unless automatically embedded in electronic report provided to the
System; and¶
(vii) Date of publication of the VIS; and Date the VIS was provided.¶
(4) ~~Billing:~~ Vaccines are billed using ~~a common procedural terminology (~~CPT~~)~~ codes on a Professional claim form (CMS 1500
Instructions and the Medical-Surgical Services Provider Guide located at: https://www.oregon.gov/~~OHA~~oha/HSD/OHP/~~Pa~~
Surgical~~.aspx.¶~~
~~(a) Adults: Billing providers shall use standard professional claim form billing procedures for adults and for any vaccine that~~
~~(b) Children:~~%20Services%20Provider%20Guide.pdf Coverage is as follows:¶
(a) EPSDT beneficiaries:¶
(A) VFC vaccines are administered only to children and adolescents through age eighteen (18) who meet VFC eligibility crit
(B) All vaccines for this age group and for conditions covered by the VFC program ~~shall~~must be obtained through the VFC p
(C) The Authority does not reimburse providers for the administration or purchase of privately purchased vaccines if the va

through the VFC program.¶
(b) Non-EPSDT beneficiaries: Billing providers must use standard professional claim form billing procedures for adults and f
VFC program; and¶
(c) For information about the VFC program or to enroll as a VFC provider, contact the Public Health Immunization Program
can be located at:
https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/IMMUNIZATIONPROVIDERRE
(5) The ~~Division~~Authority reimburses only for the administration, not the serum, of vaccines available for free through the V
Oregon Immunization Program State-Supplied Vaccine Billing Codes table in the Immunization Billing Resources section fo
the VFC Program.¶
(6) To receive reimbursement for vaccine administration, VFC program providers ~~shall~~must bill the ~~Division:¶~~
~~(a) W~~Authority with the appropriate vaccine ~~common procedural terminology (~~CPT~~)~~ code ~~included; and¶~~
~~(b) Including the appropriat~~and the modifier~~:~~ SL.¶
(7) F~~ee-for-service~~FS providers may bill the ~~Division~~Authority directly for vaccines provided to ~~client~~members. Providers m
appropriate to member plan enrollment, for the administration of VFC vaccines if the ~~client~~member is enrolled in a~~n~~ Manag
Children's Health Insurance Program (CHIP) are not considered the "payer of last resort" for administration of VFC vaccine
Statutory/Other Authority: ORS 679.543, 414.065, HB 2220 (2019 Regular Session)
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1265

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be Amended: This section provides Teledentistry guidance for the Dental/Denturist services program.

CHANGES TO RULE:

410-123-1265
Teledentistry
(1) Teledentistry can take multiple forms, both synchronous and asynchronous, including but not limited to:¶
(a) Live video, a two-way interaction between a ~~patient~~member and dentist using audiovisual technology;¶
(b) Store and forward, an asynchronous transmission of recorded health information such as radiographs, photographs, video, digital impressions, or photomicrographs transmitted through a secure electronic communication system to a dentist, and it is reviewed at a later point in time by a dentist. The dentist at a distant site reviews the information without the ~~patient~~member being present in real time;¶
(c) Remote ~~patient~~member monitoring, where personal health and dental information is collected by dental care providers in one location then transmitted electronically to a dentist in a distant site location for use in care; and¶
(d) Mobile communication devices such as cell phones, tablet computers, or personal digital assistants that may support mobile dentistry, health care, public health practices, and education.¶
(2) All Dental Services rules, criteria, limits, and billing requirements ~~stated in this rule apply to all delivery modalities referen~~apply to teledentisry service~~d~~s in ~~section (5) of this rule~~the same manner as other services.¶
(3) Billing Provider Requirements, as referenced in OAR 410-120-1990:¶
(a) Dentists providing Medicaid services ~~shall~~must be licensed to practice dentistry within the State of Oregon or within the contiguous area of Oregon and ~~shall~~must be enrolled as ~~a Health Systems Division (Division) provider~~provider with the Authority;¶
(b) Providers billing for covered teledentistry/telehealth services are responsible for the following:¶
(A) Complying with Health Insurance Portability and Accountability Act (HIPAA) and Oregon Health Authority (~~Authority~~OHA) Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records~~. See~~ (Refer to OAR 410-120-1990);¶
(B) Obtaining and maintaining technology used in the telehealth communication that is compliant with privacy and security standards in HIPAA and Department Privacy and Confidentiality Rules described in subsection (~~5)(b)(A~~1) of this rule;¶
(C) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of ~~patient~~member health information or records (whether oral or recorded in any form or medium) to unauthorized individuals; and¶
(D) Maintaining clinical and financial ~~D~~ddocumentation related to telehealth services as required in OAR~~s~~ 410-120-1360 and OAR 410-120-1990.¶
(c) A ~~patient~~member receiving services through teledentistry ~~shall~~must be notified of the right to receive interactive communication with the distant dentist and ~~shall~~must receive an interactive communication with the distant dentist upon request;¶
(d) The ~~patient~~member's chart ~~D~~ddocumentation ~~shall~~must reflect notification of the right to interactive communication with the distant site dentist; and¶
(e) A ~~patient~~member may request to have real time communication with the distant dentist at the time of the visit or within thirty (30) days of the original visit.¶
(4) General Billing Requirements:¶
(a) Unless authorized in OAR ~~410-120-1200 Exclusions or OAR~~ 410-120-1990, other types of telecommunications such as telephone calls, images transmitted via facsimile machines, and electronic mail are not covered~~:¶~~
~~(A) When those types are not being used in lieu of teledentistry, due to limited teledentistry equipment access; or¶~~
~~(B) When those types and specific services are not specifically allowed in this rule per the Oregon Health Evidence Review Commission's Prioritized List of Health Services.;~~¶
(b) The dentist may bill for teledentistry on the same type of claim form as other types of procedures unless in conflict with the Dental Services rules;¶
(c) All Dental Services rules, criteria, and limits apply to teledentistry services in the same manner as other services; and¶
(d) As stated in ORS 679.543 and this rule, payment for dental services may not distinguish between services performed using teledentistry, real time, or store-and-forward and services performed in-person.¶
(5) Teledentistry billing requirements:¶

(a) The dentist who completes diagnosis and treatment planning and the oral evaluation also documents these services using the traditional C~~DT~~urrent Dental Terminology (CDT) codes. This provider also reports the teledentistry event using D9995 or D9996 as appropriate~~.~~ (See the Dental Billing Instructions for details at: www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx~~;~~); and¶
(b) The originating site may bill a CDT code only if a separately identifiable service is performed within the scope of practice of the practitioner providing the service. The service ~~shall~~must meet all criteria of the CDT code billed.¶
~~(6) An assessment D0191 is a limited inspection performed to identify possible signs of oral or systemic disease, malformation or injury, and the potential need for referral for diagnosis and treatment. This code may be billed using the modality of teledentistry:¶~~
~~(a) When D0191 is reported in conjunction with an oral evaluation (D0120-D0180) using teledentistry, D0191 shall be disallowed even if done by a different provider;¶~~
~~(b) The assessment and evaluation may not be billed or covered by both the originating site dental care provider and a distant site dentist using the modality of teledentistry, even if due to store-and-forward review, if the dates of services are on different days.~~
Statutory/Other Authority: ORS 679.543, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1490

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be Amended: This section provides Hospital dentistry guidance for the Dental/Denturist services program.

CHANGES TO RULE:

410-123-1490
Hospital Dentistry
(1) The purpose of hospital dentistry is to provide safe, efficient dental care when providing routine (non-emergency) dental services for ~~(Division) client~~members who present special challenges that require the use of general anesthesia or intravenous (IV) conscious sedation services in an:¶
(a) Ambulatory Surgical Center (ASC)~~,~~; or¶
(b) Inpatient or outpatient hospital setting~~.~~ (Refer to OAR 410-123-1060 ~~for definitions.¶~~
~~(2) Division~~).¶
(2) The Authority reimbursement for hospital dentistry is limited to covered services and may be prorated if non-covered dental services are performed during the same hospital visit~~:¶~~
~~(a) See OAR 410-123-1060 for a definition of Division hospital dentistry services;¶~~
~~(b) Refer to OAR 410-123-1220 for a definition of covered services~~.¶
(3) Hospital dentistry is intended for the following ~~Division client~~members:¶
(a) ~~Child~~Age thre~~n~~e (~~18 or~~3) and younger~~) who:¶~~
~~(A) Through age three (3): H~~ that have extensive dental needs;¶
(~~B~~b) ~~Four (4) years of age or older: Have unsuccessfully attempted treatment in the office setting with some type of sedation or nitrous oxide;~~Per OAR Chapter 410, Division 151, EPSDT beneficiaries are covered with the following conditions:¶
(~~C~~A) ~~Have a~~Acute situational anxiety, fearfulness, extreme uncooperative behavior~~, un~~;¶
(B) An inability to communicat~~ive~~, such as a ~~client~~member with developmental or ~~ment~~intellectual disability~~, a client that is pre-verbal or extreme age where dental need~~ or a member who is ~~a~~pre~~-deemed sufficiently important that dental care cannot be deferred~~-verbal;¶
(~~D~~C) ~~N~~A need ~~the use of~~for general anesthesia (or IV conscious sedation) to protect the developing psyche;¶
(~~E~~D) ~~Have s~~Sustained extensive orofacial or dental trauma; or¶
(~~F~~E) ~~Have p~~Physical, mental, or medically compromising conditions~~; or.~~¶
(~~G~~c) ~~Have a developmental disability or other severe cognitive impairment and one or more of the following characteristics that prevent routine dental care in an office setting:¶~~
~~(i) Acute situational anxiety and extreme uncooperative behavior;¶~~
~~(ii) A physically compromising condition.¶~~
~~(b) Adults (19 or older) who:¶~~
~~(A) Have a d~~Non-EPSDT beneficiaries with:¶
(A) Developmental disability or other severe cognitive impairment, and one (1) or more of the following characteristics that prevent routine dental care in an office setting:¶
(i) Acute situational anxiety and extreme uncooperative behavior; or¶
(ii) A physically compromising condition.¶
(B) ~~Have s~~Sustained extensive orofacial or dental trauma; or¶
(C) A~~re~~ medically fragile~~, with~~ condition, such as a medical or physical condition which requires monitoring during dental procedures (i.e., coronary disease, asthma, or chronic obstructive pulmonary disease (COPD), heart failure, serious blood or bleeding disorder, or unstable diabetes or hypertension), have complex medical needs, contractures or other significant medical conditions potentially making the dental office setting unsafe for the ~~client~~member.¶
(4) Hospital dentistry is not intended for:¶
(a) ~~Client~~Member convenience~~.~~ (Refer to OAR 410-120-1200);¶
(b) A healthy, cooperative ~~client~~member with minimal dental needs;¶
(c) Members who have successfully received previous dental treatments in office settings; or¶
(~~c~~d) Medical contraindication to general anesthesia or IV conscious sedation.¶
(5) ~~Required Documentation:~~ The following information ~~shall~~must be included in the ~~client~~member's dental record:¶
(a) Informed consent: ~~Client~~Member, parental or guardian written consent ~~shall~~must be obtained prior to the use of general anesthesia or IV conscious sedation;¶
(b) Justification for the use of general anesthesia or IV conscious sedation~~: The decision to use general anesthesia~~

~~or IV conscious sedation shall take into~~, including the following considerations~~:~~:¶
(A) Alternative behavior management modalities;¶
(B) ~~Client~~Member's dental needs;¶
(C) Quality of dental care;¶
(D) Quantity of dental care;¶
(E) ~~Client~~Member's emotional development; and¶
(F) ~~Client~~Member's physical considerations.¶
(c) If treatment in an office setting is not possible, ~~D~~documentation in the ~~client~~member's dental record ~~shall~~must explain why, in the estimation of the dentist, the ~~client will~~member may not be responsive to office treatment;¶
(d) The ~~Division, or~~ Authority or Managed Care Entity (MCE) may require additional ~~D~~documentation when reviewing requests for ~~p~~Prior authorization (PA) of hospital dentistry services~~. See~~ (Refer to OAR 410-123-1160 ~~and section (6) of this rule for additional information;¶~~
~~(e) If the dentist did not proceed with a previous hospital dentistry plan approved by the Division for the same client, the Division will also);¶~~
(e) The Authority shall require clinical ~~D~~documentation explaining why the dentist did not complete the previous treatment plan.~~¶~~
~~(6) Hospital dentistry always requires prior authorization (PA) for the medical services provided by the facility:¶~~
~~(a) If a cli~~, if the dent is ~~enrolled in an MCE with plan type CCOA:¶~~
~~(A) The dentist is responsible for:¶~~
~~(i) Contacting the MCE for PA requirements and arrangements; and¶~~
~~(ii) Submitting Documentation to the MCE associated with the client record.¶~~
~~(B) The MCE should review the Documentation and discuss any concerns they have, contacting the dentist as needed;¶~~
~~(C) The total response time should not exceed 14 calendar days from the date of submission of all required Documentation for routine dental care and should follow urgent or emergent dental care timelines;¶~~
~~(b) If a client is enrolled in an MCE with plan type CCOB:¶~~
~~(A) The dentist is responsible for:¶~~
~~(i) Contacting the MCE for PA requirements and arrangements; and¶~~
~~(ii) Submitting Documentation to the MCE associated with the client record.¶~~
~~(B) The MCE should review the Documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan (CCO and FFS) involvement and monitoring;¶~~
~~(D) The MCE is responsible for payment of all facility and anesthesia services. The fee-for-service (FFS) program is responsible for payment of all dental services;¶~~
~~(c) If a client is fee-for-service (FFS) for medical services and enrolled in an MCE with plan type CCOG or CCOF:¶~~
~~(A) The dentist is responsible for faxing Documentation and a completed American Dental Association (ADA) form to the Division. Refer to the Dental Services Provider Guide;¶~~
~~(B) If the client is assigned to a Primary Care Manager (PCM) through FFS medical, the client shall have a referral from the PCM prior to any hospital service being approved by the Division;¶~~
~~(C) The Division is responsible for payment of facility and anesthesia services. The MCE is responsible for payment of all dental services;¶~~
~~(D) The Division will issue a decision on PA requests within 30 days of receipt of the request.¶~~
~~(d) If a client is FFS for both medical and dental or enrolled in MCE plan type CCOE:¶~~
~~(A) The dentist is responsible for faxing Documentation and a completed ADA form to the Division. Refer to the Dental Services Provider Guide;¶~~
~~(B) The Division is responsible for payment of all facility, anesthesia services and dental service~~t did not proceed with a previous hospital dentistry plan approved for the same member.¶
(6) Hospital dentistry always requires PA according to OAR 410-123-1160.¶
(7) For non-hospital or ASC setting anesthesia and sedation criteria refer to 410-123-1260(15).
Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.707
Statutes/Other Implemented: ORS 414.065, 414.707

AMEND: 410-123-1620

NOTICE FILED DATE: 09/20/2024

RULE SUMMARY: To be Amended: This section provides guidance on coding for the Dental/Denturist services program.

CHANGES TO RULE:

410-123-1620
~~Procedure and Diagnosis Codes ¶~~
ertaining to Coding
(1) The ~~Division~~Authority requires providers to use the standardized code sets adopted by the Health Insurance Portability and Accountability Act (HIPAA) and the Centers for Medicare and Medicaid Services (CMS).¶
(2) Unless otherwise directed in rule, providers ~~shall~~must accurately code claims according to the national standards in effect for the date the service(s) was provided.¶
(~~2~~3) Procedure codes:¶
(a) For dental services, and procedures that are directly related to the teeth and the structures supporting the teeth, use Current Dental Terminology (CDT) codes as maintained and distributed by the American Dental Association (ADA). Contact the ~~American Dental Association (~~ADA~~)~~ to obtain a current copy of the CDT reference manual~~.~~;¶
(b) For physician provided oral health services performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, cheek, roof of mouth), use Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes~~.~~; and¶
(c) Such procedures are covered under the ~~Division~~Authority's medical surgical program ~~found in Oregon Administrative Rule (OAR) 410-130-0000~~(refer to Chapter 410, Division 130).¶
(~~3~~4) Diagnosis codes:¶
(a) International Classification of Diseases 10th Clinical Modification (ICD-10-CM) diagnosis codes are not required for dental services submitted on an ADA claim form; and¶
(b) When OAR 410-123-1260 requires services to be billed on a professional claim form, ICD-10-CM diagnosis codes are required~~. R~~ (refer to ~~the Medical-Surgical administrative rules for additional information, OAR~~Chapter 410-~~d~~, Division 130).¶
(~~4~~5) Ancillary codes:¶
(a) ~~Ancillary codes for hospitalization, m~~Medication and deep sedation are provided for hospitalization, for conditions appearing above the funding line of the Prioritized List ~~of Health Services~~, and subject to ~~T~~the Prioritized List's ancillary guideline notes ~~when applicable. Ancillary codes must be dentally or medically appropriate and part of the care for a funded condition on The List.~~¶
(b) Must be medically necessary and dentally appropriate. Some ancillary codes are not eligible for separate payment~~. See~~ (Refer to OAR 410-123-120~~6~~0 for more detail on codes not to be billed separately).¶
(~~b~~c) Approved ancillary codes ~~for all members include D7990, D9211, D9212, D9220, D9221, D9222, D9239, D9310, and D9997~~(subject to OAR 410-123-1260) for all members are as follows:¶
(A) D7990- Emergency Tracheotomy;¶
(B) D9211 - Regional block anesthesia;¶
(C) D9212 - Trigeminal division block anesthesia;¶
(D) D9220 - Deep sedation/general anesthesia, first 30 minutes;¶
(E) D9221 - Deep sedation/general anesthesia, each additional 15 minutes;¶
(F) D9222 - Deep sedation/general anesthesia, first 15 minutes;¶
(G) D9239 - Intravenous moderate (conscious) sedation/analgesia, first 15 minutes;¶
(H) D9310 - Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician; and¶
(I) D9997 - Dental case management, patients with special health care needs.¶
(~~c~~d) D9248 ~~is covered for clients under age 21 and l~~- (non-intravenous conscious sedation) is covered for EPSDT beneficiaries as follows:¶
(A) Limited to four (4) times per year for ~~clients under 13 years of age.~~members age 13 and younger;¶
(B) Includes payment for monitoring and Nitrous Oxide~~.~~; and¶
(C) Requires use of multiple agents to receive payment.¶
(~~d~~e) D9410 ~~is covered for all clients and shall be only used~~- (House/extended care facility call) is covered only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience.
Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065