Division of Medical Assistance Programs
Policy and Planning Section

Dental Services Administrative Rulebook

Chapter 410, Division 123

Effective May 10, 2016

Table of Contents

410-123-1000 – Eligibility, Providing Services and Billing 1

410-123-1060 – Definition of Terms 3

410-123-1100 – Services Reviewed by the Division of Medical Assistance Programs 7

410-123-1160 – Prior Authorization 8

410-123-1200 – Services Not To Be Billed Separately 11

410-123-1220 – Coverage According to the Prioritized List of Health Services (T) 13

410-123-1230 – Buy-Ups 15

410-123-1240 – The Dental Claim Invoice 16

410-123-1260 – OHP Dental Benefits (T) 17

410-123-1490 – Hospital Dentistry 40

410-123-1510 – Dental Care Access Standards for Pregnant Women (T) 45

410-123-1540 – Citizen/Alien-Waived Emergency Medical (CAWEM) 46

410-123-1600 – Managed Care Organizations 47

410-123-1620 – Procedure and Diagnosis Codes 48

410-123-1640 – Prescriptions 49

410-123-1000 – Eligibility, Providing Services and Billing

(1) Eligibility:

(a) Providers are responsible to verify client eligibility and must do so before providing any service or billing the Division of Medical Assistance Programs (Division) or any Oregon Health Plan (OHP) Prepaid Health Plan (PHP);

(b) The Division may not pay for services provided to an ineligible client even if services were authorized. Refer to General Rules OAR 410-1201140 (Verification of Eligibility) for details.

(2) Co-payments for OHP clients may be required for certain services. See General Rules OAR 410-120-1230 for specific information on co-pays.

(3) Billing:

(a) Providers must 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 signed provider enrollment agreement;

(b) 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 must be billed before the Division or any OHP PHP 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 (OAR 410120-1280);

(c) 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 must have occurred:

(i) Prior to the client's loss of eligibility; and

(ii) For dentures for adults age 21 and older, no later than six months from the date of the last extraction from the jaw for which the denture is being provided;

(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:

(i) The client's OHP eligibility; or

(ii) Six months after the extractions (for dentures for adults);

(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. These are the only exceptions to the Division's General Rules Program rule (OAR 410-120-1280). All other services must be billed using the date the service was provided;

(d) Refer to OAR 410-123-1160 for information regarding dental services requiring prior authorization (PA). Refer to OAR 410-123-1100 for information regarding dental services that require providers to submit reports for review ("by report" - BR) prior to reimbursement;

(e) The client's records must include documentation to support the appropriateness of the service and level of care rendered;

(f) The Division shall only reimburse for dental services that are dentally appropriate as defined in OAR 410-123-1060;

(g) 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);

(4) 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.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

410-123-1060 – Definition of Terms

(1) Anesthesia — The following depicts the Division of Medical Assistance Programs' (Division) usage of certain anesthesia terms; however, for further details refer also to the Oregon Board of Dentistry administrative rules (OAR chapter 818, division 026):

(a) Conscious Sedation:

(A) Deep Sedation — A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance maintaining a patient airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained;

(B) Minimal Sedation — A minimally depressed level of consciousness produced by non-intravenous pharmacological methods that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous pharmacological method is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous pharmacological method in minimal sedation;

(C) Moderate Sedation — A drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained;

(b) General Anesthesia — A drug-induced loss of consciousness during which the patient is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patient airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired;

(c) Local Anesthesia — The elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug;

(d) Nitrous Oxide Sedation — An induced controlled state of minimal sedation produced solely by the inhalation of a combination of nitrous oxide and oxygen in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command;

(2) Citizen/Alien-Waived Emergency Medical (CAWEM) — Refer to OAR 410-120-0000 for definition of clients who are eligible for limited emergency services under the CAWEM benefit package. The definition of emergency services does not apply to CAWEM clients. OAR 410-120-1210 provides a complete description of limited emergency coverage pertaining to the CAWEM benefit package.

(3) Covered Services — Services on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) that have been funded by the legislature and identified in specific program rules. Services are limited as directed by General Rules — Excluded Services and Limitations (OAR 410-120-1200), the Division’s Dental Services Program rules (chapter 410, division 123), and the Prioritized List. Services that are not considered emergency dental services as defined by OAR 410-123-1060(12) are considered routine services.

(4) Dental Hygienist — A person licensed to practice dental hygiene pursuant to state law.

(5) Dental Hygienist with Expanded Practice Dental Hygiene Permit (EPDH) — A person licensed to practice dental hygiene with an EPDH permit issued by the Board of Dentistry and within the scope of an EPDH permit pursuant to state law.

(6) Dental Practitioner — A person licensed pursuant to state law to engage in the provision of dental services within the scope of the practitioner's license and/or certification.

(7) Dental Services — 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.

(8) Dental Services Documentation — Shall meet the requirements of the Oregon Dental Practice Act statutes; administrative rules for client records and requirements of OAR 410-120-1360, "Requirements for Financial, Clinical and Other Records;" and any other documentation requirements as outlined in the Dental rules.

(9) Dentally Appropriate — In accordance with OAR 410-141-0000, services that are required for prevention, diagnosis, or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community, evidence-based medicine, and professional standards of care as effective;

(c) Not solely for the convenience of an OHP member or a provider of the service; and

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a member.

(10) Dentist — A person licensed to practice dentistry pursuant to state law.

(11) Denturist — A person licensed to practice denture technology pursuant to state law.

(12) Direct Pulp Cap — The procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.

(13) Emergency Services:

(a) Refer to OAR 410-120-0000 for the complete definition of emergency services. (This definition of emergency services does not apply to CAWEM clients. OAR 410-120-1210 provides a complete description of limited emergency coverage pertaining to the CAWEM benefit package);

(b) Covered services for an emergency dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment. This includes services to treat the following conditions:

(A) Acute infection;

(B) Acute abscesses;

(C) Severe tooth pain;

(D) Unusual swelling of the face or gums; or

(E) A tooth that has been avulsed (knocked out);

(c) 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 services. Routine dental treatment or treatment of incipient decay does not constitute emergency care;

(14) Hospital Dentistry — 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 center, inpatient, or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

(15) Medical Practitioner — A person licensed pursuant to state law to engage in the provision of medical services within the scope of the practitioner's license and certification.

(16) Procedure Codes — The procedure codes in the Dental Services rulebook (OAR chapter 410, division 123) refer to Current Dental Terminology (CDT), unless otherwise noted. Codes listed in this rulebook and other documents incorporated in rule by reference are subject to change by the American Dental Association (ADA) without notification.

(17) Standard of Care — What reasonable and prudent practitioners would do in the same or similar circumstances.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

410-123-1100 – Services Reviewed by the Division of Medical Assistance Programs

(1) Services requiring prior authorization (PA): See OAR 410-123-1160 for information about services that require PA and how to request PA.

(2) By Report procedures:

(a) Request for payment for dental services listed as “by report” (BR), or services not included in the procedure code listing must be submitted with a full description of the procedure, including relevant operative or clinical history reports and/or radiographs. Payment for BR procedures will be approved in consultation with a Division of Medical Assistance Program (Division) dental consultant;

(b) Refer to the “Covered and Non-Covered Dental Services” document for a list of procedures noted as BR. See OAR 410-123-1220.

(3) Treatment Justification: The Division may request the treating dentist to submit appropriate radiographs or other clinical information that justifies the treatment:

(a) Before issuing PA;

(b) In the process of utilization/post payment review; or

(c) In determining responsibility for payment of dental services.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

410-123-1160 – Prior Authorization

(1) Division of Medical Assistance Programs (Division) prior authorization (PA) requirements:

(a) For fee-for-service (FFS) dental clients, the following services require PA:

(A) Crowns (porcelain fused to metal);

(B) Crown repair;

(C) Retreatment of previous root canal therapy – anterior;

(D) Complete dentures;

(E) Immediate dentures;

(F) Partial dentures;

(G) Prefabricated post and core in addition to fixed partial denture retainer;

(H) Fixed partial denture repairs;

(I) Skin graft; and

(J) Orthodontics (when covered pursuant to OAR 410-123-1260);

(b) Hospital dentistry always requires PA, regardless of the client's enrollment status. Refer to OAR 410-123-1490 for more information;

(c) Oral surgical services require PA when performed in an ambulatory surgical center (ASC) or an outpatient or inpatient hospital setting and related anesthesia. Refer to OAR 410-123-1260 (Oral Surgery Services), and the current Medical Surgical Services administrative rule OAR 410130-0200 for information;

(d) Maxillofacial surgeries may require PA in some instances. Refer to the current Medical Surgical Services administrative rule 410-130-0200, for information.

(2) The Division does not require PA for outpatient or inpatient services related to life-threatening emergencies. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(3) How to request PA:

(a) Submit the request to the Division in writing. Refer to the Dental Services Provider Guide for specific instructions and forms to use. Telephone calls requesting PA will not be accepted;

(b) Treatment justification: The Division may request the treating dentist to submit appropriate radiographs or other clinical information that justifies the treatment:

(A) When radiographs are required they must be:

(i) Readable copies;

(ii) Mounted or loose;

(iii) In an envelope, stapled to the PA form;

(iv) Clearly labeled with the dentist's name and address and the client's name; and

(v) If digital x-ray, they must be of photo quality;

(B) Do not submit radiographs unless it is required by the Dental Services administrative rules or they are requested during the PA process.

(4) The Division will issue a decision on PA requests within 30 days of receipt of the request. The Division will provide PA for services when:

(a) The prognosis is favorable;

(b) The treatment is practical;

(c) The services are dentally appropriate; and

(d) A lesser-cost procedure would not achieve the same ultimate results.

(5) PA does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service.

(6) For certain services and billings, the Division will seek a general practice consultant or an oral surgery consultant for professional review to determine if a PA will be approved. The Division will deny PA if the consultant decides that the clinical information furnished does not support the treatment of services.

(7) For managed care PA requirements:

(a) For services other than hospital dentistry, contact the client’s Dental Care Organization (DCO) for PA requirements for individual services and/or supplies

listed in the Dental Services administrative rules. DCOs may not have the same PA requirements for dental services as listed in this administrative rule;

(b) For hospital dentistry, refer to OAR 410-123-1490 for details regarding PA requirements.

Stat. Auth.: ORS 413.042, 414.065 and 414.071

Stats. Implemented: ORS 414.065

410-123-1200 – Services Not To Be Billed Separately

(1) Services that are not to be billed separately may be included in the Current Dental Terminology (CDT) codebook and may not be listed as combined with another procedure; however, they are considered to be either minimal, included in the examination, part of another service, or included in routine post-op or follow-up care.

(2) The following services do not warrant an additional fee:

(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;

(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.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

410-123-1220 – Coverage According to the Prioritized List of Health Services (T)

(1) This rule incorporates by reference the “Covered and Non-Covered Dental Services” document dated January 1, 2016, and located on the Health System Division, Medical Assistance Programs (Division) website at: http://www.oregon.gov/oha/healthplan/Pages/dental.aspx.

(a) The “Covered and Non-Covered Dental Services” document lists coverage of Current Dental Terminology (CDT) procedure codes according to the Oregon Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) and the client’s specific Oregon Health Plan benefit package;

(b) This document is subject to change if there are funding changes to the Prioritized List.

(2) Changes to services funded on the Prioritized List are effective on the date of the Prioritized List change:

(a) The Division administrative rules (chapter 410, division 123) will not reflect the most current Prioritized List changes until they have gone through the Division rule filing process;

(b) For the most current Prioritized List, refer to the HERC website at www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx;

(c) In the event of an alleged variation between a Division-listed code and a national code, the Division shall apply the national code in effect on the date of request or date of service.

(3) Refer to OAR 410-123-1260 for information about limitations on procedures funded according to the Prioritized List. Examples of limitations include frequency and client’s age.

(4) The Prioritized List does not include or fund the following general categories of dental services, and the Division does not cover them for any client. 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;

(c) Mastique or veneer procedure;

(d) Orthodontia (except when it is treatment for cleft palate);

(e) Overhang removal;

(f) Procedures, appliances, or restorations solely for aesthetic or cosmetic purposes;

(g) Temporomandibular joint dysfunction treatment; and

(h) Tooth bleaching.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-123-1230 – Buy-Ups

(1) Buying-up as defined in OAR 410-120-0000 is prohibited.

(2) Providers are not permitted to bill and accept payment from the Division of Medical Assistance Programs (Division) or a managed care plan for a covered service when:

(a) A non-covered service has been provided; and

(b) Additional payment is sought or accepted from the client.

(3) If a client wants to purchase a non-covered service or item, the client must be responsible for full payment. A payment from the Division or the managed care plan for a covered service cannot be credited toward the non-covered service and then an additional client payment sought to obtain, for example, a gold crown (not covered) instead of the stainless steel crown (covered).

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

410-123-1240 – The Dental Claim Invoice

(1) Providers: Refer to the Dental Services Provider Guide for information regarding claims submissions and billing information.

(2) Providers billing dental services on paper must use the 2012 version of the American Dental Association (ADA) claim form.

(3) Submission of electronic claims directly or through an agent must comply with the Electronic Data Interchange (EDI) rules. OAR 943-120-0100 et seq.

(4) Specific information regarding Health Insurance Portability and Accountability Act (HIPAA) requirements can be found on the Division Web site.

(5) Providers will not include any client co-payments on the claim when billing for dental services.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065

410-123-1260 – OHP Dental Benefits (T)

(1) GENERAL:

(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

(A) Refer to Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the EPSDT program, eligible clients, and related services. EPSDT dental services include, but are not limited to:

(i) Dental screening services for eligible EPSDT individuals; and

(ii) Dental diagnosis and 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;

(B) Providers shall provide EPSDT services for eligible Division of Medical Assistance Programs (Division) clients according to the following documents:

(i) The Dental Services Program administrative rules (OAR chapter 410, division 123), for dentally appropriate services funded on the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List); and

(ii) The "Oregon Health Plan (OHP) — Recommended Dental Periodicity Schedule," dated January 1, 2010, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document at www.oregon.gov/oha/healthplan/Pages/dental.aspx;

(b) Restorative, periodontal, and prosthetic treatments:

(A) Documentation shall be included in the client's charts to support the treatment. Treatments shall be consistent with the prevailing standard of care and may be limited as follows:

(i) When prognosis is unfavorable;

(ii) When treatment is impractical;

(iii) A lesser-cost procedure would achieve the same ultimate result; or

(iv) The treatment has specific limitations outlined in this rule;

(B) Prosthetic treatment, including porcelain fused to metal crowns, are limited until rampant progression of caries is arrested and a period of adequate oral

hygiene and periodontal stability is demonstrated; periodontal health needs to be stable and supportive of a prosthetic.

(2) ENHANCED ORAL HEALTH SERVICES IN PRIMARY CARE SETTINGS:

(a) Topical fluoride treatment:

(A) For children under 19 years of age, topical fluoride varnish may be applied by a licensed medical practitioner during a medical visit. Providers must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with either the appropriate Current Dental Terminology (CDT) code (D1206-Topical Fluoride Varnish) or the appropriate Current Procedural Terminology (CPT) code (99188 - Application of topical fluoride varnish by a physician or other qualified health care professional);

(B) Topical fluoride treatment from a medical practitioner counts toward the overall maximum number of fluoride treatments, as described in subsection (4) of this rule;

(b) Assessment of a patient:

(A) For children under six years of age, CDT code D0191-Assessment of a Patient is covered as an enhanced oral health service in medical settings;

(B) For reimbursement in a medical setting, D0191-Assessment of a patient must include all of the following components:

(i) Caries risk assessment using a standardized tool endorsed by Oregon Oral Health Coalition, the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics;

(ii) Anticipatory guidance and counseling with the client's caregiver on good oral hygiene practices and nutrition;

(iii) Referral to a dentist in order to establish a dental home;

(iv) Documentation in medical chart of risk assessment findings and service components provided;

(C) For reimbursement, the performing provider must meet all of the following criteria:

(i) Be a physician (MD or DO), an advance practice nurse, or a licensed physician assistant; and

(ii) Hold a certificate of completion from one of the following approved training programs within the previous three years:

(I) Smiles for Life; or

(II) First Tooth through the Oregon Oral Health Coalition;

(D) For reimbursement, the medical practitioners must bill:

(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;

(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;

(iii) Using a professional claim format with the appropriate CDT code (D0191-Assessment of a Patient);

(E) D0191 Assessment of a Patient may be reimbursed under this subsection up to a maximum of once every 12 months;

(F) D0191 Assessment of a Patient from a medical practitioner does not count toward the maximum number of CDT code D0191-Assessment of a Patient services performed by a dental practitioner described in subsection three (3) of this rule;

(c) For tobacco cessation services provided during a medical visit, follow criteria outlined in OAR 410-130-0190;

(3) DIAGNOSTIC SERVICES:

(a) 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 must not bill D0140 and D0170 for routine dental visits;

(D) The Division only covers oral exams performed by medical practitioners when the medical practitioner is 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;

(iii) 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);

(iv) For children under 19 years of age, a maximum of twice every 12 months; and

(v) 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 oral evaluations/exams;

(c) Radiographs:

(A) The Division shall reimburse for routine radiographs once every 12 months;

(B) The Division shall reimburse bitewing radiographs for routine screening once every 12 months;

(C) The Division shall reimburse a maximum of six radiographs for any one emergency;

(D) For clients under age six, radiographs 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 (D0330) or intra-oral complete series (D0210) 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-oral complete series (D0210). The minimum standards for reimbursement of intra-oral 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 full mouth complete series (D0210), 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.

(4) PREVENTIVE SERVICES:

(a) 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 oral 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 oral health care;

(D) Are coded using the appropriate Current Dental Terminology (CDT) coding:

(i) D1110 (Prophylaxis — Adult) — Use for clients 14 years of age and older; and

(ii) D1120 (Prophylaxis — Child) — Use for clients under 14 years of age;

(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 oral health factors are clearly documented in chart notes for clients who:

(i) Have high-risk oral 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 oral health care;

(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care; or

(v) Are under seven years old with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.;

(D) Fluoride limits include any combination of fluoride varnish (D1206) or other topical fluoride (D1208);

(c) Sealants (D1351):

(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 brief counseling is provided:

(i) Ask patients about their tobacco-use status at each visit and record information in the chart;

(ii) Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and a strong personalized message to seek help; and

(iii) Refer patients who are ready to quit, utilizing internal and external resources, to complete the remaining three A's (assess, assist, arrange) of the standard intervention protocol for tobacco;

(B) The Division allows a maximum of ten services within a three-month period;

(e) Space management:

(A) The Division shall cover fixed and removable space maintainers (D1510, D1515, D1520, and D1525) only for clients under 19 years of age;

(B) The Division may not reimburse for replacement of lost or damaged removable space maintainers.

(f) The Division limits reimbursement for interim caries arresting medicament application (D1354) to silver diamine fluoride applications, with a maximum of two applications per year.

(5) RESTORATIVE SERVICES:

(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 (D2941) is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration.

(H) Reattachment of tooth fragment (D2921) 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 (D2950) 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 (D2951) 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) The Division shall cover the following only for clients under 21 years of age or who are pregnant:

(i) Prefabricated plastic crowns (D2932) are allowed only for anterior teeth, permanent or primary;

(ii) Stainless steel crowns (D2930/D2931) are allowed only for anterior primary teeth and posterior permanent or primary teeth;

(iii) Prefabricated stainless steel crowns with resin window (D2933) are allowed only for anterior teeth, permanent or primary;

(iv) Prefabricated post and core in addition to crowns (D2954/D2957);

(v) Permanent crowns (resin-based composite — D2710 and D2712, and porcelain fused to metal (PFM) — D2751 and D2752) 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 according to (E)(i) of this rule;

(III) Only for clients at least 16 years of age; and

(IV) Rampant caries are arrested, and the client demonstrates a period of oral hygiene before prosthetics are proposed;

(vi) PFM crowns (D2751 and D2752) 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;

(D) 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;

(E) Crown repair (D2980) is limited to only anterior teeth.

(6) ENDODONTIC SERVICES:

(a) Endodontic therapy:

(A) Pulpal therapy on primary teeth (D3230 and D3240) is covered only for clients under 21 years of age;

(B) For permanent teeth:

(i) Anterior and bicuspid endodontic therapy (D3310 and D3320) is covered for all OHP Plus clients; and

(ii) Molar endodontic therapy (D3330):

(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 does 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 (D3430) 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.

(7) PERIODONTIC SERVICES:

(a) Surgical periodontal services:

(A) Gingivectomy/Gingivoplasty (D4210 and D4211) — limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral 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 (D4341 and D4342):

(i) For clients through age 20, allowed once every two years;

(ii) For clients age 21 and over, allowed once every three years;

(iii) A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;

(iv) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater:

(I) D4341 is allowed for quadrants with at least four or more teeth with pockets 5 mm or greater;

(II) D4342 is allowed for quadrants with at least two teeth with pocket depths of 5 mm or greater;

(v) 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 (D4355):

(i) For clients through age 20, allowed only once every two years;

(ii) For clients age 21 and older, allowed once every three years;

(c) Periodontal maintenance (D4910):

(A) For clients through age 20, allowed once every six months;

(B) For clients age 21 and older:

(i) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;

(ii) Allowed once every twelve months;

(iii) 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) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and

(H) D4910 (Periodontal maintenance).

(8) REMOVABLE PROSTHODONTIC SERVICES:

(a) Clients age 16 years and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140);

(b) The Division limits full dentures for clients age 21 and older to only those clients who are recently edentulous:

(A) For the purposes of this rule:

(i) "Edentulous" means all teeth removed from the jaw for which the denture is being provided; and

(ii) "Recently edentulous" means the most recent extractions from that jaw occurred within six months of the delivery of the final denture (or, for fabricated prosthetics, the final impression) for that jaw;

(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 (D5211-D5212):

(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 and under 21 years of age, the Division shall replace full or partial dentures once every ten years, only if dentally appropriate. This does not imply that replacement of dentures or partials shall be done once every ten years, but only when dentally appropriate;

(B) For clients 21 years of age and older, the Division may not cover replacement of full dentures but shall cover replacement of partial dentures once every ten (10) years only if dentally appropriate;

(C) The ten year limitations apply to the client regardless of the client's OHP or Dental Care Organization (DCO)/Coordinated Care Organization (CCO) enrollment status at the time the client's last denture or partial was received. For example: A client receives a partial on February 1, 2002, and becomes a FFS OHP client in 2005. The client is not eligible for a replacement partial until February 1, 2012. The client gets a replacement partial on February 3, 2012

while FFS and a year later enrolls in a DCO or CCO. The client would not be eligible for another partial until February 3, 2022, regardless of DCO, CCO, or FFS enrollment;

(D) Replacement of partial dentures with full dentures is payable ten years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral 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 oral 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) Adjusting complete and partial dentures, per arch (D5410-D5422);

(ii) Replacing missing or broken teeth on a complete denture, each tooth (D5520);

(iii) Replacing broken tooth on a partial denture, each tooth (D5640);

(iv) Adding tooth to existing partial denture (D5650);

(B) A maximum of two times per year for:

(i) Repairing broken complete denture base (D5510);

(ii) Repairing partial resin denture base (D5610);

(iii) Repairing partial cast framework (D5620);

(iv) Repairing or replacing broken clasp (D5630);

(v) Adding clasp to existing partial denture (D5660);

(g) Replacement of 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 oral 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 oral 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; and

(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 (D5820-D5821, 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;

(9) MAXILLOFACIAL PROSTHETIC SERVICES:

(a) Fluoride gel carrier (D5986) is limited to those patients whose severity of oral 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 the “Covered and Non-Covered Dental Services” document and 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 or PHP, bill medical maxillofacial prosthetics to the CCO or PHP;

(C) For clients receiving medical services through FFS, bill the Division.

(10) ORAL SURGERY SERVICES:

(a) Bill the following procedures in an accepted dental claim format using CDT codes:

(A) Procedures that are directly related to the teeth and supporting structures that are not due to a medical condition or diagnosis, including such procedures performed in an ambulatory surgical center (ASC) or an inpatient or outpatient hospital setting;

(B) Services performed in a dental office setting or an oral surgeon’s office:

(i) Such services include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs, and follow-up visits;

(ii) Refer to OAR 410-123-1160 for any PA requirements for specific procedures;

(b) Bill the following procedures using the professional claim format and the appropriate American Medical Association (AMA) CPT procedure and ICD-10 diagnosis codes:

(A) Procedures that are a result of a medical condition (i.e., fractures, cancer);

(B) Services requiring hospital dentistry that are the result of a medical condition/diagnosis (i.e., fracture, cancer);

(c) Refer to the “Covered and Non-Covered Dental Services” document to see a list of CDT procedure codes on the Prioritized List that may also have CPT medical codes. See OAR 410-123-1220. The procedures listed as “medical” on the table may be covered as medical procedures, and the table may not be all-inclusive of every dental code that has a corresponding medical code;

(d) For clients enrolled in a DCO or CCO responsible for dental services, the DCO or CCO shall pay for those services in the dental plan package;

(e) Oral surgical services performed in an ASC or an inpatient or outpatient hospital setting:

(A) Require PA;

(B) For clients enrolled in a CCO or FCHP, the CCO or FCHP shall pay for the facility charge and anesthesia services. For clients enrolled in a Physician Care Organization (PCO), the PCO shall pay for the outpatient facility charge (including ASCs) and anesthesia. Refer to the current Medical Surgical Services administrative rules in OAR chapter 410, division 130 for more information;

(C) If a client is enrolled in a CCO or PHP, the provider shall contact the CCO or PHP for any required authorization before the service is rendered;

(f) All codes listed as “by report” require an operative report;

(g) The Division covers payment for tooth re-implantation only in cases of traumatic avulsion where there are good indications of success;

(h) Biopsies collected are reimbursed as a dental service. Laboratory services of biopsies are reimbursed as a medical service;

(i) The Division does not cover surgical excisions of soft tissue lesions (D7410-D7415);

(j) Extractions — Includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service;

(k) Surgical extractions:

(A) Include local anesthesia and routine post-operative care;

(B) The Division limits payment for surgical removal of impacted teeth or removal of residual tooth roots to treatment for only those teeth that have acute infection or abscess, severe tooth pain, or unusual swelling of the face or gums;

(C) The Division does not cover alveoloplasty in conjunction with extractions (D7310 and D7311) separately from the extraction;

(D) The Division covers alveoplasty not in conjunction with extractions (D7320-D7321) only for clients under 21 years of age or who are pregnant;

(l) Frenulectomy/frenulotomy (D7960) and frenuloplasty (D7963):

(A) The Division covers either frenulectomy or frenuloplasty once per lifetime per arch only for clients under age 21;

(B) The Division covers maxillary labial frenulectomy only for clients age 12 through 20;

(C) The Division shall cover frenulectomy/frenuloplasty in the following situations:

(i) When the client has ankyloglossia;

(ii) When the condition is deemed to cause gingival recession; or

(iii) When the condition is deemed to cause movement of the gingival margin when the frenum is placed under tension;

(m) The Division covers excision of pericoronal gingival (D7971) only for clients under age 21 or who are pregnant.

(11) ORTHODONTIA SERVICES:

(a) The Division limits orthodontia services and extractions to eligible clients:

(A) With the ICD-10-CM diagnosis of:

(i) Cleft palate; or

(ii) Cleft palate with cleft lip; and

(B) Whose orthodontia treatment began prior to 21 years of age; or

(C) Whose surgical corrections of cleft palate or cleft lip were not completed prior to age 21.

(b) PA is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate or cleft lip shall be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record shall include diagnosis, length, and type of treatment;

(d) Payment for appliance therapy includes the appliance and all follow-up visits;

(e) Orthodontists evaluate orthodontia treatment for cleft palate/cleft lip 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;

(f) 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;

(g) The Division shall use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;

(h) 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;

(i) Code:

(A) D8660 — PA required (reimbursement for required orthodontia records is included);

(B) Codes D8010-D8690 — PA required.

(12) ADJUNCTIVE GENERAL AND OTHER SERVICES:

(a) Fixed partial denture sectioning (D9120) 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 (D9223and D9243);

(B) The Division reimburses providers for general anesthesia or IV sedation as follows:

(i) D9223 or D9243: For each 15-minute period, up to three and a half hours on the same day of service.

(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 (D9230) per date of service, not by time;

(D) Oral pre-medication anesthesia for conscious sedation (D9248):

(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 oral medications used during a procedure and is not intended for "take home" medication;

(c) The Division limits reimbursement of house/extended care facility call (D9410) 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) Oral 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 for these codes using the professional claim format.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

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 of Medical Assistance Programs (Division) clients who present special challenges that require the use of general anesthesia or IV conscious sedation services in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting. Refer to OAR 410-1231060 for definitions.

(2) Division 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 and the “Covered and Non-Covered Dental Services” document.

(3) Hospital dentistry is intended for the following Division clients:

(a) Children (18 or younger) who:

(A) Through age 3 -- Have extensive dental needs;

(B) 4 years of age or older -- Have unsuccessfully attempted treatment in the office setting with some type of sedation or nitrous oxide;

(C) Have acute situational anxiety, fearfulness, extreme uncooperative behavior, uncommunicative such as a client with developmental or mental disability, a client that is pre-verbal or extreme age where dental needs are deemed sufficiently important that dental care cannot be deferred;

(D) Need the use of general anesthesia (or IV conscious sedation) to protect the developing psyche;

(E) Have sustained extensive orofacial or dental trauma;

(F) Have physical, mental or medically compromising conditions; or

(G) 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 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) Have sustained extensive orofacial or dental trauma; or

(C) Are medically fragile, have complex medical needs, contractures or other significant medical conditions potentially making the dental office setting unsafe for the client.

(4) Hospital dentistry is not intended for:

(a) Client convenience. Refer to OAR 410-120-1200;

(b) A healthy, cooperative client with minimal dental needs; or

(c) Medical contraindication to general anesthesia or IV conscious sedation.

(5) Required documentation: The following information must be included in the client's dental record:

(a) Informed consent: client, parental or guardian written consent 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 must take into consideration:

(A) Alternative behavior management modalities;

(B) Client’s dental needs;

(C) Quality of dental care;

(D) Quantity of dental care;

(E) Client’s emotional development;

(F) Client’s physical considerations;

(c) If treatment in an office setting is not possible, documentation in the client's dental record must explain why, in the estimation of the dentist, the client will not be responsive to office treatment;

(d) The Division, Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) may require additional documentation when reviewing requests for prior authorization (PA) of hospital dentistry services. See 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 require clinical 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 client is enrolled in a CCO or PHP and a Dental Care Organization (DCO):

(A) The dentist is responsible for:

(i) Contacting the CCO or PHP for PA requirements and arrangements; and

(ii) Submitting documentation to both the CCO or PHP and DCO;

(B) The CCO or PHP and DCO should review the documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan involvement and monitoring;

(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/emergent dental care timelines;

(D) The CCO or PHP is responsible for payment of all facility and anesthesia services. The DCO is responsible for payment of all dental professional services;

(b) If a client is enrolled in a Physician Care Organization (PCO) and a Dental Care Organization (DCO):

(A) The PCO is responsible for payment of all facility and anesthesia services provided in an outpatient hospital setting or an ASC. The Division is responsible for payment of all facility and anesthesia services provided in an inpatient hospital setting. The DCO is responsible for payment of all dental professional services;

(B) The dentist is responsible for:

(i) Contacting the PCO, if services are to be provided in an outpatient setting or an ASC, for PA requirements and arrangements; or

(ii) Contacting the Division, if services are to be provided in an inpatient setting; and

(iii) Submitting documentation to both the PCO (or the Division) and the DCO;

(B) The PCO or the Division and the DCO should review the documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan involvement and monitoring;

(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/emergent dental care timelines;

(b) If a client is fee-for-service (FFS) for medical services and enrolled in a DCO:

(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 must 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 DCO is responsible for payment of all dental professional services;

(D) The Division will issue a decision on PA requests within 30 days of receipt of the request;

(c) If a client is enrolled in an CCO or PHP and is FFS dental:

(A) The dentist is responsible for contacting the CCO or PHP to obtain the PA and arrange for the hospital dentistry;

(B) The dentist is responsible for submitting required documentation to the CCO or PHP;

(C) The CCO or PHP is responsible for all facility and anesthesia services. The Division is responsible for payment of all dental professional services;

(d) If a client is FFS for both medical and dental:

(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 professional charges.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

410-123-1510 – Dental Care Access Standards for Pregnant Women (T)

(1) The Authority shall establish access standards for dental care for pregnant women who receive Oregon Health Plan (OHP) benefits through the fee-for-service delivery system. Those standards shall be as good as or better than the standards for clients who receive services through the managed care delivery system. Access shall be monitored by the Authority to determine the length of time it takes for a pregnant client in fee-for-service to receive a dental appointment. The standard shall be for the client to be seen, treated, or referred within the following time frames:

(a) Emergency dental care standard: Client shall be seen or treated within 24 hours;

(b) Urgent dental care standard: Client shall receive an appointment within one to two weeks or as indicated in the initial screening in accordance with OAR 410-123-1060;

(c) Routine dental care standard: Clients shall be seen for routine care within an average of four weeks, unless there is a documented special clinical reason that would make access longer than four weeks appropriate;

(d) Initial dental screening or examination standard: Client shall be seen within four weeks.

(2) The Authority shall reach out to pregnant clients by e-mail, mail, phone, or in person to assess each pregnant client's need for oral health care within one month of either enrollment in OHP or record of pregnancy, whichever is later. Within one week of assessment, the Authority shall refer the client to an appropriate oral health provider.

(3) The Authority shall generate regular reporting to monitor fee-for-service delivery system performance to these standards.

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.065

410-123-1540 – Citizen/Alien-Waived Emergency Medical (CAWEM)

(1) CAWEM clients who are not pregnant (benefit package identifier CWM) have a limited benefit package. Dental coverage is limited to dental services provided in an emergency department hospital setting. Refer to OAR 410-120-1210(4)(e).

(2) CAWEM clients who are pregnant (benefit package identifier CWX) receive the OHP Plus dental benefit package as described in OAR 410-123-1260.

(3) All CAWEM clients are exempt from enrollment in a Dental Care Organization (DCO) or Coordinated Care Organization (CCO). Providers must bill the Division directly for any allowable services provided.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065

410-123-1600 – Managed Care Organizations

(1) The Division of Medical Assistance Programs (Division) contracts with Managed Care Organizations (MCO) and Primary Care Managers (PCM) to provide medical services for clients under the Division (Title XIX and Title XXI services):

(a) MCOs for dental services are called Dental Care Organizations (DCO). See General Rules OAR 410-120-0250 -- Managed Care Organizations for definitions and responsibilities of MCOs;

(b) See General Rules OAR 410-120-1210(4) -- Medical Assistance Programs and Delivery Systems for a description of how clients receive services through MCOs and PCMs.

(2) The Division prepays DCOs to cover dental services, including the professional component of any services provided in an Ambulatory Surgical Center (ASC) or an outpatient or inpatient hospital setting for hospital dentistry. See OAR 410-123-1490 for more information about hospital dentistry.

(3) The Division will not pay for services covered by a MCO; reimbursement is a matter between the MCO and the provider.

(4) For clients enrolled in a DCO, it is the responsibility of the dental provider to coordinate all dental services with the client's DCO prior to providing services.

Stat. Auth.: ORS 413.042, 414.065, 414.725

Stats. Implemented: ORS 414.725

410-123-1620 – Procedure and Diagnosis Codes

(1) The Division 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). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided.

(2) Procedure codes:

(a) For dental services, use Current Dental Terminology (CDT) codes as maintained and distributed by the American Dental Association. Contact the American Dental Association (ADA) to obtain a current copy of the CDT reference manual. Current Dental Terminology (including procedure codes, definitions (descriptors) and other data) is copyrighted by the ADA. © 2012 American Dental Association. All rights reserved. Applicable Federal Acquisition Regulation Clauses/Department of Defense Federal Acquisition Regulation Supplement (FARS/DFARS) apply;

(b) For physician services and other health care services, use Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes.

(3) 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;

(b) When Oregon Administrative Rule (OAR) 410-123-1260 requires services to be billed on a professional claim form, ICD-10-CM diagnosis codes are required. Refer to the Medical-Surgical administrative rules for additional information, OAR 410 division 130.

Stat. Auth.: ORS 413.042 & 414.065
Stats. Implemented: ORS 414.065

410-123-1640 – Prescriptions

(1) Follow criteria outlined in OAR 410-121-0144.

(2) Practitioner-Managed Prescription Drug Plan (PMPDP) -- Follow criteria outlined in PMPDP -- OAR 410-121-0030.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.065