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NOTICE OF PROPOSED RULEMAKING INCLUDING STATEMENT OF NEED & FISCAL IMPACT

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

FILED

10/28/2025 2:04 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Updated language to improve benefit clarity and readability.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2025 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:
Brenna Bird
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/17/2025

TIME: 2:00 PM - 2:45 PM

OFFICER: Brenna Bird

REMOTE HEARING DETAILS

MEETING URL: [Click here to join the meeting](#)

PHONE NUMBER: 1-669-254-5252

CONFERENCE ID: 1601736301

SPECIAL INSTRUCTIONS:

Topic: Public Hearing OARs 123 Dental Rules

Time: Nov 17, 2025 02:00 PM Pacific Time (US and Canada)

Join ZoomGov Meeting

<https://www.zoomgov.com/j/1601736301?pwd=rmzsLKd6iBFVoBc4SqTNoWuNeG7za3.1>

Meeting ID: 160 173 6301

Passcode: 607856

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NEED FOR THE RULE(S)

The Dental/Denturist Services rules were updated to remove out-of-date references, add definitions, and improve benefit guidance and rule readability.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

OARs referenced in this revision:

OHA's Chapter 410 rules, Divisions 120, 200, 130, 141, 151,

OHA's Chapter 333 rules, Divisions 024, 046

Oregon Board of Dentistry OAR's: 818-012-0006, 818-012-0007

ORSs referenced: 413.550, 679.543

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

OHA and RAC Committee members do not anticipate any negative effects or implications to racial equity as a result of these revisions.?

FISCAL AND ECONOMIC IMPACT:

OHA and RAC Committee members do not anticipate any fiscal or economic impacts as a result of this update.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Provider

(2)(a) None

(b) None

(c) None

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Dental subcontractor administrators participated as RAC members and many of their suggestions for benefit clarity were integrated as added or revised language.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

410-123-1060, 410-123-1160, 410-123-1250, 410-123-1260, 410-123-1262, 410-123-1265, 410-123-1490, 410-123-1510, 410-123-1620

AMEND: 410-123-1060

RULE SUMMARY: This rule has been amended to bring definitions into alignment across the Oregon Health Plan. Some definitions were added, removed, or edited for clarity. For example, the definition for 'bicuspid teeth' was removed as it aligns with the definition for 'premolar,' which is more commonly used.

CHANGES TO RULE:

410-123-1060

Definitions and Acronyms ¶

The acronyms and definitions within this rule specifically pertain to dental services. This rule does not include an exhaustive list of acronyms and definitions that apply to dental services. All Authority rules are intended to be used in conjunction with the General Rules for Oregon Health Plan (OHP) OAR 410 division 120 and the OAR 410 division 141. Other acronyms and definitions that apply to dental services are found in OARs 410-141-3500, 410-120-0000, 410-200-0015, and Chapter 410, Division 130. ¶

(1) "Alveoplasty" 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. ¶

~~(2) "Ancillary codes" are procedure codes for treatments or services that are not provided alone, but along with other treatments or services. "Services" has the meaning provided in OAR 410-120-0000. ¶~~

~~(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. These services must be provided in accordance with Chapter 818, Division 26. ¶~~

(4) "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. ¶

(5) "Apexification" is a dental treatment provided on permanent teeth when the roots of the teeth are incompletely formed, to encourage development and 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 indicated by the numbers 20, 21, 28, 29. ¶~~

~~(8) "Billing" definition is "Billing" definition and requirements are provided in OAR 410-120-1280. ¶~~

~~(98) "By Report" (BR) has the meaning as provided in OAR 410-120-0000. ¶~~

~~(109) "Canine 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 are 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 ¶

(d) Permanent lower canine teeth are indicated by the numbers 22, 27. ¶

~~(110) "Composite restorations" are white/tooth colored ¶~~

~~fillings clinically appropriate" has the meaning provided in OAR 410-120-0000. ¶~~

~~(121) "Current Dental Terminology (CDT)" codes are the alphanumeric codes that identify a specific dental procedure, as designated by the federal government, and used by the American Dental Association. ¶~~

~~(13) "Dental" means teeth and supporting structures. ¶~~

~~(14) "Dental Care Organization (DCO)" as provided for Compact Of Free Association (COFA) Dental Program is a dental-only enrollment type under the Oregon Health Plan (OHP) as defined in OARS 414.025 who provide the following: ¶~~

~~(a) Dental services to the coordinated care organization's members, on a pre-paid capitated basis; ¶~~

~~(b) Administrative services on behalf of the 0-200-0445. ¶~~

~~(12) "Composite restorations" are white, tooth-colored 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) 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

fillings.

(13) "Concurrent needs" means simultaneously having a diagnosed need and other characteristics as listed that may affect service delivery.

(14) "Coordinated Care Organization (CCO)" has the meaning provided in OAR 410-141-3500.

(15) "Covered Services" has the meaning provided in OAR 410-120-0000.

(16) "Current Dental Terminology (CDT)" codes are the alphanumeric codes that identify a specific dental procedure, as designated by those non-covered services.

(16) "Dental Emergency Services" has the meaning as provided in OAR 410-120-0000. For the purpose of the Authority's rules, Dental Emergency Services is synonymous with emergency dental care and emergency oral health care, a federal government, and used by the American Dental Association.

(17) "Dental" means teeth and supporting structures.

(178) "Dental Hygienist" has the meaning as provided in OAR 410-120-0000.

(189) "Dental Hygienist with "Expanded Practice Dental Hygiene (EPDH) Permit-" has the meaning as provided in OAR 410-120-0000.

(1920) "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.

(201) "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).

(212) "Dental Services Documentation" means meeting the requirements of the Oregon Dental Practice Act statutes, administrative rules for 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 rules). subcontractor has the meaning provided in OAR 410-120-0000.

(223) "Dental Therapist" has the meaning provided in ORS 679.014 AR 410-120-0000.

(234) "Dentally Appropriate" has the meaning as provided in OAR 410-120-0000.

(245) "Dentist" has the meaning as provided in OAR 410-120-0000.

(256) "Denturist" has the meaning as provided in OAR 410-120-0000.

(267) "Distant Site" means the site where the dentist is being contacted for consultation by the originating site.

(278) "Documentation" means dental services documentation which meets the requirements of the Oregon Dental Practice Act statutes, administrative rules for 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~~ Services).

(289) "Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)" means the 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)" described in OAR 410-151-0000.

(30) "EPSDT Beneficiary" has the meaning as provided in OAR 410-151-0001.

(31) "Eligibility" has the meaning as provided in OAR Chapter 410, Division 200.

(32) "Emergency Dental Condition" means any incident involving the teeth and/or 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.~~ For additional criteria, refer to "Emergency Medical Condition" provided in 410-120-0000. ¶

~~(33)~~ "Emergency Dental Services" has the same meaning as "Dental Emergency Services" provided in OAR 410-120-0000. This meaning is synonymous with "emergency dental care" and "emergency oral health care." ¶

~~(334)~~ "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. ¶

~~(35)~~ "Fee-for-Service (FFS)" is a Medicaid model in which the state pays participating physicians, clinics, hospitals and other providers a fee for each service they furnish. ¶

~~(36)~~ "Fee-for-Service Provider" has the meaning provided in OAR 410-120-0000. ¶

~~(37)~~ "First Tooth" is a curriculum aimed to reduce early childhood caries in Oregon. ¶

~~(348)~~ "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. ¶

~~(35)~~ "Fraud" has the meaning as provided in OAR 410-120-0000. ¶

~~(369)~~ "Gingivectomy" is the surgical removal of diseased gum tissue, to prevent damage to the bone. ¶

~~(3740)~~ "Gingivoplasty" is the surgical reshaping of gum tissue around the teeth. ¶

~~(3841)~~ "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. ¶

~~(39)~~ Certified or Qualified, has the meaning given to those terms in ORS 413.550. ¶

~~(42)~~ "Hemoglobin A1c (HbA1c) Testing" is a measure of the amount of glucose attached to red blood cells and directly relates to average blood glucose levels. ¶

~~(403)~~ "Health Evidence Review Commission (HERC)" has the meaning provided in OAR 410-120-0000. ¶

~~(44)~~ "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 upper incisors are indicated by the numbers 7, 8, 9, 10; and; ¶

(d) Permanent lower incisors are indicated by the numbers 23, 24, 25, 26. ¶

~~(41)~~ "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 Meaningful Language Access Interpreter services may also be accessed for deaf or hard of hearing members to ensure effective communication, as required by the Americans with Disabilities Act. The interpreter must be a certified or qualified health care interpreter (HCI) (refer to chapter 950, division 50). ¶

~~(425)~~ "Malocclusion" is a misalignment or incorrect relation of the upper and lower teeth when the jaw is closed. ¶

~~(436)~~ "Mandibular" refers to the lower jaw and the lower teeth. ¶

~~(447)~~ "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. ¶

~~(468)~~ "Maxillofacial" means relating to the face, head, neck or jaw. Treatments may be necessary due to congenital defects or caused by trauma or disease. trauma, disease, or congenital defects. ¶

~~(479)~~ "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. ¶

~~(4850)~~ "Medically Necessary" has the meaning as provided in OAR 410-120-0000. ¶

~~(4951)~~ "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. ¶

~~(502)~~ "Oral Health" refers to the health of teeth, gums, lips, tongue, inner cheeks, and 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. ¶

~~(513)~~ "Oral Health 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. ¶

~~(524)~~ "Oregon Health Authority (Authority)" means the organization that administers Medicaid (Oregon Health Plan or OHP) in Oregon. ¶

~~(55)~~ "Oregon Health Plan (OHP)" is the Medicaid program in Oregon, and has the meaning provided in OAR 410-

120-0000.

- (536) "Originating Site" means the site where the member 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.
- (547) "Periapical X-rays" capture an image of an entire tooth, from the crown to the root tip.
- (558) "Periodontal scaling" and "root planing" refer to non-surgical treatments to remove plaque and tartar from teeth roots and gums.
- (569) "Periodontal" refers to the soft tissues supporting and surrounding teeth.
- (5760) "Permanent teeth", often referred to as adult teeth, are the second set of teeth people get. There are 32 permanent teeth which include incisors, canines, and premolars, and molars. They are identified by the numbers 1 through 32.
- (5861) "Posterior 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.
- (5962) "~~Practitioner-Managed Prescription Drug Plan~~" (PMPDP) has the meaning provided in OAR 410-121-0-00030.
- (603) "Premolars" are permanent teeth ~~and also called bicuspid teeth. They~~ that are positioned 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.
- (624) "Prescriptions" means services as outlined in OAR 410-121-0144.
- (635) "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 indicated by the letters A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T. //
- (646) "Prior Authorization (PA)" has the meaning as provided in OAR 410-120-0000.
- (657) "Prioritized List of Health Services (Prioritized List)" has the meaning as provided in OAR 410-120-0000.
- (668) "Procedure Codes" means 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.
- (67) "~~Program Integrity~~" has the meaning as provided in OAR 410-120-1360 through 410-120-1580.
- (689) "Prophylaxis" is a dental service to thoroughly clean the teeth.
- (6970) "Prosthodontics" refers to the replacement of missing or damaged teeth with artificial devices, most commonly dentures.
- (701) "~~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 410-120-1360000.
- (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 seven (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~~ tartar from teeth and roots, ~~on file.~~
- (75) "Smiles for Life" is a national oral health curriculum that Oregon Medicaid has adopted to improve oral health access. ?
- (76) "Standard of Practice" means what reasonable and prudent practitioners may do in the same or similar circumstances.
- (77) "Teledentistry" means using electronic and telecommunications technologies, for the distance delivery of dental care services and clinical information designed to improve a member's health status and to enhance delivery of the health care services and clinical information ~~(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 meaning as provided in OAR 410-120-1280.
- (80) "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 conditions 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.

(81) "Veterans Dental Program" is a dental-only enrollment type under the Oregon Health Plan (OHP) as defined in OAR 410-200-0450. ¶

(82) Young Adults with Special Health Care Needs (YSHCN)" is a benefit eligibility program as defined in OAR 410-200-0455.

Statutory/Other Authority: ORS 413.042, ORS 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1160

RULE SUMMARY: This rule has been amended to include updated billing guidance and coding, as well as to reflect coverage changes, and improve readability.

CHANGES TO RULE:

410-123-1160

Prior Authorization

(1) The Authority covers the following services ~~require only with~~ Prior Authorization (PA) ~~approval~~: ¶

(a) Crowns: ¶

(A) Porcelain fused to metal (D2751, D2752); and ¶

(B) Porcelain ceramic (D2740); ¶

(b) Crown repair necessitated by restorative material failure (D2980), covered only for anterior teeth (D2980); ¶

(c) Retreatment of previous root canal therapy (D3346), covered only for anterior teeth (D3346); ¶

(d) Complete dentures (D5110, D5120); ¶

(e) Immediate dentures (D5130, D5140); ¶

(f) Partial dentures - resin base (D5211, D5212); ¶

(g) Immediate partial dentures (D5221, D5222); ¶

(gh) Prefabricated post and core in addition to fixed partial denture retainer; (D2954); ¶

(hi) Fixed partial denture repairs (D6980); ¶

(ij) Skin graft (D7920); ¶

(jk) Comprehensive Orthodontic treatment (D8070, D8080, D8090, D8091); ¶

(kl) Hospital dentistry (Refer to OAR 410-123-1490); ¶

(lm) Oral surgical services, when performed in an: ¶

(A) Ambulatory surgical center (ASC); or ¶

(B) Outpatient or inpatient hospital setting and related anesthesia (Refer to OAR 410-130-0200); and ¶

(mn) Maxillofacial surgeries, 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: ¶

(a) Medically 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. ¶

(3) The Authority does not require PA for outpatient or inpatient services related to a "Dental Emergency Condition" as defined in OAR 410-123-1060; ¶

(a) The member's clinical medical 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. (3) The frequency allowed for the following services may be increased with approved PA. ¶

(a) Frequencies of Periodontal scaling and root planing (D4341, D4342), and Scaling in the presence of generalized moderate to severe inflammation (D4346) may be increased from the once (1) every two (2) years limitation when: ¶

(aA) Medically necessary and dentally appropriate (refer to EPSDT requirements in OAR chapter 410, division 151), such as due to presence of due to periodontal disease found during pregnancy or 12 months postpartum; and ¶

(B) Documentation in the member's record that supports the need for increased scaling and root planing; ¶

(b) The frequency of Periodontal maintenance (D4910) may be increased from the once (1) in six (6) months limitation when: ¶

(A) Medically necessary and dentally appropriate due to periodontal disease found during pregnancy; or 12 months postpartum; ¶

(bB) Member's medical Documentation in the member's record documents the need; ¶

(c) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth and clinical attachment loss charting and radiographs; and ¶

(5C) Denture replacement requires PA. Periodontal maintenance is covered only following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three (3) years. ¶

(64) Hospital dentistry always requires PA for the medical services provided by the facility: ¶

(a) If a member is enrolled in an MCE CCO with plan type CCOA: ¶

(A) The dental subcontractor or dental provider is responsible for: ¶

(i) Contacting the MCECCO for PA requirements and arrangements; and ¶

(ii) Submitting documentation to the MCECCO associated with the member record. ¶

- (B) The MCECCO 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~~ seventeen (17) calendar days from the date of ~~submission~~ receipt 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 MCECCO with plan type CCOB;¶
- (A) The dentist is responsible for:¶
- (i) Contacting the MCECCO for PA requirements and arrangements; and.¶
- (ii) Submitting documentation to the MCECCO associated with the member record.¶
- (B) The MCECCO 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 MCECCO 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 MCECCO with plan type CCOF or CCOG and is enrolled in FFS for physical health; ~~the~~.¶
- (A) The ~~D~~dentist is responsible for sending, by secure email or faxing, documentation and a completed American Dental Association (ADA) form to the Authority (Refer to the Dental Services Provider Guide);.¶
- (B) ~~M~~The member must have a referral from the PCM prior to any hospital service being approved by the Authority if assigned to a Primary Care Manager (PCM) through FFS medical, the prior approval from the CCO for dental services, and from the Authority for the facility payment;¶
- (C) The Authority is responsible for payment of facility and anesthesia services;¶
- (D) ~~MCE~~The CCO 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~~ seven (7) calendar days of date received.¶
- ~~(d) If a member is enrolled in Fee-for-Service for both physical health and dental health or enrolled in MCE~~ the Coordinated Care Organization 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 Provider Guide); and.¶
- (B) Authority is responsible for payment of all facility, anesthesia services and dental services.¶
- (75) How to request PA:¶
- (a) Submit the PA request to the Authority in writing. Refer to www.oregon.gov/oha/HSD/OHP/Pages/PA.aspx or the Dental Services Provider Guide for specific instructions and forms to use. Telephone calls requesting PA shall not be accepted;.¶
- ~~(b) Documentation submitted when requesting authoriz~~ Submitted documentation must support the medical justification for the service. The authorization PA request must contain:¶
- (A) A cover sheet detailing relevant provider and recipient Medicaid numbers;.¶
- (B) Requested date(s) of service;.¶
- (C) HCPCS Healthcare Common Procedure Coding System (HCPCS) or Current Dental Terminology (CDT) Procedure code requested;.¶
- (D) Amount of service or units requested; and.¶
- (E) Any additional clinical information supporting medical justification for the services requested.¶
- ~~(c) Treatment justification:~~ The Authority 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:¶
- ~~(iA)~~ Readable copies and of photo of diagnostic quality;¶
- ~~(iiB)~~ Mounted or loose;.¶
- ~~(iiiC)~~ In an envelope, stapled to the PA form;¶
- ~~(iv and~~¶
- ~~(D)~~ Clearly labeled with the dental provider's name and address and the member's name; and¶
- ~~(v) Of photo quality when it is a digital x-ray.~~¶
- ~~(B).~~¶
- ~~(d) Do not submit radiographs unless it is~~ they are required by the Dental Services administrative rules, or they are requested during the PA process.¶
- ~~(86)~~ The Authority shall issue a decision on PA requests within ~~thirty (30)~~ seven (7) calendar days of upon receipt of the request. The Authority shall provide PA for services when:¶
- (a) The prognosis is favorable; which refers to a:¶
- (A) Prediction that an individual's health condition is likely to improve or lead to a positive outcome; and¶
- (B) Determination made by a healthcare provider based on medical evidence;¶
- (b) The treatment is practical;.¶
- (c) The services are medically necessary and dentally appropriate; and.¶

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

(97) PA approval does not guarantee member eligibility or reimbursement. It is the responsibility of the provider to check the member's eligibility on each date of service.¶

(108) The Authority ~~shall~~may seek a general practice consultant or an ~~oral surgery consultan~~ licensed dental specialist for:¶

(a) Professional review to determine if a PA shall be approved; and,¶

(b) Shall deny PA if the consultant decides that the clinical information furnished does not support the treatment of services.

Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.707

Statutes/Other Implemented: ORS 414.065, 414.707

AMEND: 410-123-1250

RULE SUMMARY: This rule has been amended for clarity and readability, as well as to correct outdated CMS references.

CHANGES TO RULE:

410-123-1250

HbA1c Testing

(1) Hemoglobin A1c (HbA1c) testing for at risk 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 ~~dentist~~ licensed oral health providers which supports identification of those 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. ¶

(3) Licensed oral health providers must share the HbA1c test results with the member's primary care provider (PCP) to promote care collaboration and avoid duplication. ¶

~~(a) If the test results indicate risk, the dental provider must e, and: ¶~~

(a) Establish bi-directional communication with the member's PCP to communicate test results and initiate a referral for evaluation, diagnosis, treatment, and collaboration of care; and ¶

(b) Communicate progress of treatment and oral health status. ¶

(4) Licensed oral health providers 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): ¶

~~(a) For laboratory enrollment requirements and processes, as identified at~~ Information about CLIA in Oregon including enrollment requirements and processes is located on the Authority's Clinical Laboratory Regulation webpage <https://www.oregon.gov/oha/PH/LaboratoryServices/ClinicalLaboratoryRegulation/Pages/index.aspx>; ¶

~~(b) In order to perform HbA1c testing, Oregon licensed oral health providers and facilities must apply for a Certificate of Waiver (CMS-1600-116 application form), 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, for information. ¶~~

~~(5) In determining the need for dental HbA1c testing, dentists must~~ licensed oral health providers must use best clinical judgement when considering member risk factors based on appropriate, consensus-based guidelines and the dentist's best clinical judgement. ¶

(6) Release of Information (ROI): ¶

~~(a) P~~ Licensed oral health providers must ensure a member's ROI is on file in the member's record; ¶

~~(b) Shall if the member does not have a/ Primary Care Provider (PCP), CP, licensed oral health providers must: ¶~~

(A) Inform the member of the test findings and direct them toward resources containing more information and encourage the member to become a patient of record with a PCP for their other health needs; and ¶

(B) Document actions in the member's record, with follow-up at the next visit. ¶

(c) Referrals must be tracked and documented in the member's record; ¶

(d) P Licensed oral health providers must provide sufficient information regarding the purpose of the test and the procedure, including its ~~its~~ their relevance to both oral and general health, so that a 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

RULE SUMMARY: This rule has been amended for readability, and to correct obsolete references. Language was also changed to align with statutes related to the Oregon Health Plan.

CHANGES TO RULE:

410-123-1260

Coverage, Limitations, Exclusions: ¶

(1) The 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 associates 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 alveolitis (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; ¶
- (a) Providers must be licensed to practice dentistry and enrolled as a Medicaid provider as required by OAR 410-120-1260; and ¶
- (b) All billing and rendering providers must comply with OAR Chapter 410 Division 120 rules and these Chapter 410, Division 123 rules which provide direction in the delivery of dental services and in the preparation of dental care claims./ For additional requirements for Coordinated Care Organizations (CCOs) refer to OAR 410-141-3835./ ¶
- (2) This rule incorporates the Oregon Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List), included through the stated Funding Line, unless otherwise excluded in rule, 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) The providers rendering services and receiving payment for any of the services identified in these Chapter 410, Division 123, rules must make records available for audit, as required by OAR 410-123-1620. ¶
- (4) Providers must comply with the Authority rules for dental services covered by Oregon Health Plan (OHP) which include the: ¶
 - (a) Medical-Dental Fee Schedule found on the OHP Fee-for-Service Fee Schedule site found at (<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 Medicaid Covered Dental Services list (https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-Covered-Dental-Services/495m-gmu2/about_data); ¶
 - (d) Approved ancillary codes (https://data.oregon.gov/Health-Human-Services/Group-6060-Ancillary-Services/fq2m-i6ix/about_data); and ¶
 - (e) Oregon Administrative Rules (OAR), Medicaid covered services, in Chapter 410. ¶
- (5) All coverage limitations and exclusions are subject to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) review as required by Chapter 410, Division 151. ¶
- (6) Covered dental and oral health services provided in non-dental settings including medical, community and school settings by providers who are medical providers such as physicians and nurses. Criteria are limitations are as follows: ¶
 - (a) Dental Screening of a patient (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. Providers must hold a certificate of completion of the Smiles for Life or First Tooth training; and ¶
 - (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. Providers must hold a certificate of completion of the Smile for Life or First Tooth training; ¶
 - (c) Application of topical fluoride (99128, 99188, D1206, D1208), requires providers to hold a certificate of completion of the Smiles for Life or First Tooth training; ¶
 - (A) The application of topical fluoride may be delegated by providers to staff, in accordance to their professional boards' scope of practice; ¶
 - (B) For EPSDT beneficiaries - limited to twice (2) every 12 months; ¶
 - (C) For non-EPSDT beneficiaries - limited to once (1) every 12 months; ¶
 - (D) Additional applications may available, up to a total of four (4) per member within a 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 or 12 months postpartum; ¶
 - (iii) Have physical disabilities and cannot perform adequate daily dental health care; ¶
 - (iv) Have developmental disabilities or other severe cognitive impairment and 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 in teeth, severely crowded teeth, poor diet, etc. ¶
 - (d) Application of silver diamine fluoride (0792T) by a physician or other healthcare professional is a covered benefit when the member has non-cavitated caries. Providers must hold a certificate of completion of the Smiles for Life or First Tooth training; ¶
 - (A) For all members - limited to two (2) applications per 12 months; and ¶
 - (B) Documentation of need must be included on submitted claims. ¶

(7) Diagnostic services (CDT codes D0100 - D0999): ¶

(a) Dental screenings (D0190) and dental assessments (D0191) do not take the place of the need for comprehensive dental evaluations and exams; ¶

(A) For EPSDT beneficiaries - a maximum of twice (2) every 12 months; ¶

(B) For non-EPSDT beneficiaries - a maximum of once (1) every 12 months; and ¶

(C) Reimbursable only if an exam (D0120-D0180) is not performed on the same date of service at the same place of service. ¶

(D) 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 (or dental subcontractor); and ¶

(E) Anticipatory guidance and counseling on good dental hygiene practices and nutrition is to be provided to the member's caregiver. ¶

(b) The Authority requires dental subcontractors and dental providers to conduct an intake screening of individuals who are enrolled in the Veterans Dental Program within 60 days of the enrolled individual contacting the dental subcontractor or dental provider. This intake screening requires one of the following services being provided, as clinically appropriate: ¶

(i) D0150 - comprehensive oral evaluation of a new or established patient; ¶

(ii) D0180 - comprehensive periodontal evaluation of a new or established patient; or ¶

(iii) D0120 - periodic oral evaluation of an established patient, if the individual enrolled in the Veterans Dental Program is an established patient. ¶

(c) Caries risk assessment and documentation findings (D0601, D0602, D0603) should be encountered in the member's chart but are not separately reimbursable. ¶

(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; and ¶

(D) The member's FFS provider or the CCO shall make available care coordination as needed. ¶

(e) Clinical Dental evaluations (Exams) for: ¶

(A) EPSDT beneficiaries (refer to Division 151): ¶

(i) The Authority covers exams (D0120, D0145, D0150, or D0180) a maximum of twice (2) every 12 months. These codes are not billable if D0191 is billed for the same date of service, at the same place of service. Limitations are as follows: ¶

(I) D0150: once (1) every 12 months when performed by the same practitioner; ¶

(II) D0180: once (1) every 12 months. ¶

(ii) The Authority must reimburse D0160 only once (1) every 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 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) The Authority covers diagnostic imaging as follows: ¶

(A) Intraoral - complete series (D0210) - One (1) time every five (5) years, unless D0330 has been billed within the five (5) year period; ¶

(B) Intraoral - first image (D0220) - One (1) time every 12 months; ¶

(C) Intraoral - additional images (D0230) - Under age six (6), maximum of five (5) times every 12 months. Not to exceed five (5) times on the same date of service for any provider. Radiographs may be billed separately one (1) time every 12 months; ¶

(D) Intraoral - occlusal image (D0240) - One (1) time every 12 months. Not to exceed four (4) times on the same date of services for any provider; ¶

(E) Extraoral images (D0250 and D0251) - One (1) time every 12 months; ¶

(F) Bitewing single image (D0270) - Maximum of two (2) times every 12 months if not billing D0272; ¶

(G) Bitewing two images (D0272) - Under age six (6), maximum of one (1) time every 12 months if not billing D0270 twice; ¶

(H) Bitewing, multiple images (D0273, D0274 and D0277) - One (1) time every 12 months; ¶

(I) Other TMJ images (D0321) - By Report; ¶

(J) Dental tomographic survey (D0322) - One (1) time every 12 months; ¶

(K) Panoramic image (D0330) - One (1) time every five (5) years, unless D0210 has been billed within the five (5) year period; ¶

(L) Cone beam CT capture (D0364, D0365, D0366, D0367) - Only when performed as part of the pre-orthodontic treatment examination; and ¶

(M) 3d print of 3d surface scan (D0396). ¶

(g) The Authority covers panoramic radiographic image (D0330) or intra-oral complete series (D0210) once (1) every five (5) years, but both cannot be done within the five (5) year period; ¶

(h) Members must be a minimum of six (6) years old for billing intra-oral complete series. The minimum standards for reimbursement of intra-oral complete series are: ¶

(A) For members age six (6) through 11/a minimum of 10 periapical and two (2) bitewings for a total of 12 films; and ¶

(B) For members ages 12 and older/a minimum of 10 periapical and four (4) bitewings for a total of 14 films. ¶

(i) 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; ¶

(j) Additional films are covered if medically necessary and dentally appropriate (e.g., fractures); ¶

(k) 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; ¶

(l) 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; and ¶

(m) Digital radiographs, if printed, must be on photo paper to assure sufficient diagnostic quality of images. ¶

(8) Preventative Services (CDT codes D1000-D1999): ¶

(a) Topical application of fluoride (D1206, D1208, 99128, 99188): ¶

(A) For EPSDT beneficiaries, limited to twice (2) every 12 months; ¶

(B) For non-EPSDT beneficiaries, limited to once (1) every 12 months; ¶

(C) Additional topical fluoride treatments are available, up to a total of four (4) treatments per member within a 12 month period, when high-risk conditions or dental health factors are clearly documented by D0603 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 or 12 months postpartum; ¶

(iii) Have physical disabilities and cannot perform adequate daily dental health care; ¶

(iv) Have developmental disabilities or other severe cognitive impairment and 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 in teeth, severely crowded teeth, poor diet, etc. ¶

(D) Fluoride limits include any combination of fluoride varnish or other topical fluoride. ¶

(b) Dental sealants (D1351) are covered for EPSDT beneficiaries as follows: ¶

(A) Limited to members under 16 years of age. Members age 16 and older require PA; ¶

(B) Permanent molars only (additional teeth require PA); ¶

(C) Only one (1) sealant treatment per tooth every five (5) years, except when visible evidence of clinical failure; and ¶

(D) The original provider is responsible for any repair or replacement during the 36-month period of initial sealant placement. ¶

(c) Dental prophylaxis (D1110, D1120) are not covered by the Authority if provided on the same date of service as D4355, D4346 or D4910. Coverage is as follows: ¶

(A) EPSDT beneficiaries, limited to twice (2) per 12 months; ¶

(B) Non-EPSDT beneficiaries, limited to once (1) per 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) Silver diamine fluoride (SDF) application (D1354, D1355): ¶

(A) Is covered for all members; ¶

(B) Reimbursement by the Authority is per application, not per tooth; ¶

(C) Is limited to two (2) applications per year (additional applications for EPSDT is allowable with approved PA); ¶

(D) Requires that the tooth or teeth numbers be included on the claim; ¶

(E) When SDF is applied for the treatment (rather than prevention) of caries, use D1354. The treated tooth or teeth must be; ¶

(i) Covered with topical application of fluoride; or ¶

(ii) Covered with an interim direct restoration (D2940) or a permanent restoration when medically necessary and dentally appropriate. ¶

(F) When SDF is applied for the treatment of caries by a non-dental professional (0792T), refer to the guidance in the earlier section of this rule. Coverage is limited to two (2) applications per year. ¶

(e) Immunization counseling (D1301) is covered as described in 410-123-1262. ¶

(f) The Authority covers Tobacco counseling for the control and prevention of oral disease (D1320) for services provided during a dental visit, when the using the Five-A approach outlined below, limited to a maximum of 10 services within a three (3) month period, when the following is provided: ¶

(A) ASK: Identify the member's tobacco-use status at each visit and record information in the chart; ¶

(B) 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; ¶

(C) ASSESS: Refer member to external resources or internal counseling and intervention protocol if the tobacco user is willing to make a quit attempt; ¶

(D) ASSIST: Provide counseling and pharmacotherapy to help member quit tobacco, if dental provider chooses to assist; and ¶

(E) 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. ¶

(g) The Authority covers Nutritional counseling (D1310) and Counseling for high risk substance use (D1321) for services provided during a dental visit using the Five-A approach outlined below, limited to two (2) services within a 12 month period, when the following is provided: ¶

(A) ASK: Identify the member's behavior; ¶

(B) ADVISE: Urge the member to change behavior; ¶

(C) ASSESS: Determine the member's willingness to make change; ¶

(D) ASSIST: Help the member with a plan and resources, if dental provider chooses; and ¶

(E) ARRANGE: Schedule follow-up support, if dental provider chooses. ¶

(h) Space maintenance (passive appliances) are: ¶

(A) Covered for EPSDT beneficiaries; and ¶

(B) Not replaceable when lost or damaged. ¶

(9) The Authority's coverage limitations of restorative, periodontic, and prosthetic treatments include the following: ¶

(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 outlines in this rule. ¶

(c) Periodontal health needs to be stable and supportive of a prosthetic. Prosthetic treatment, including porcelain fused to metal crowns and porcelain/ceramic crowns are limited until documented by examination; ¶

(A) Rampant caries is arrested; and ¶

(B) A period of adequate dental hygiene and periodontal stability is demonstrated. ¶

(10) 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 direct restorations (D2940) on primary dentition are covered to restore and prevent progression of dental caries. They are not definitive restorations and are not to be used as a base or liner under a 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; and ¶

(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration. ¶

(b) Indirect crowns and related services: ¶

(A) The fee for the crown includes payment for preparation of the gingival tissue; ¶

(B) The Authority covers crowns only when: ¶

(i) There is significant loss of clinical crown, no other restorations restore function; ¶

(ii) The crown-to-root ratio is 50:50 or better, and the tooth is restorable to function without other surgical procedures; and ¶

(iii) Endodontic therapy alone (with or without a post) is not a consideration, nor are aesthetics. ¶

(C) The Authority covers core buildup only when: ¶

(i) Necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture; ¶

(ii) Done in conjunction with a crown; and ¶

(iii) More than 50 percent of the tooth structure is remaining for coverage of the core buildup. ¶

(D) Reimbursement of retention pins is per tooth, not per pin; ¶

(E) Payment shall be made only upon final cementation; and ¶

(F) Partial payment will not be made for an undelivered crown. ¶

(G) Prefabricated stainless steel crowns are allowed only for anterior primary teeth and posterior permanent or primary teeth; ¶

(H) 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 adequate 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 clinical attachment loss 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. ¶

(I) 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. ¶

(J) Crown repair is limited to anterior teeth. ¶

(11) Endodontic Services (CDT codes D3000-D3999): ¶

(a) All radiographic images taken during the course of root canal therapy and all post-treatment radiographic images are included in the fee for the root canal procedure. At least one pre-treatment radiographic image demonstrating the need for the procedure, and one post-treatment radiographic images that demonstrates the result of the treatment, must be maintained in the member's record. ¶

(b) Endodontic therapy: ¶

(A) For EPSDT beneficiaries: all primary teeth, permanent anterior teeth, premolars, first molars and second molars; ¶

(B) For members who are pregnant or 12 months postpartum: permanent anterior teeth, premolars, and first molars; ¶

(C) For non-pregnant adults: anterior teeth and premolars; and ¶

(D) 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. ¶

(c) Endodontic retreatment and apicoectomy: ¶

(A) The Authority does not cover retreatment of a previous root canal or apicoectomy for premolars 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. ¶

(d) 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; ¶

(e) The Authority covers endodontics if the tooth is restorable to function with direct or indirect restoration without other surgical procedures. ¶

(f) Apexification/recalcification procedures: ¶

(A) The Authority limits payment for apexification to permanent teeth only; ¶

(B) D3351-D3353 are limited to once (1) per tooth; and ¶

(C) Covered only for EPSDT beneficiaries, or members who are pregnant or 12 months postpartum. ¶

(12) Periodontic Services (CDT codes D4000-D4999): ¶

(a) The Authority does not reimburse the following codes if performed on the same date of service D1110, D1120, D4210, D4211, D4341, D4346, D4355, and D4910. ¶

(b) Surgical periodontal services: ¶

(A) Gingivectomy/Gingivoplasty (D4210, D4211) coverage is limited to severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to dental hygiene procedures (e.g., Dilantin hyperplasia), and includes six (6) months routine postoperative care; and ¶

(B) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) is considered part of the restoration and is not separately billable. ¶

(c) Non-surgical periodontal services: ¶

(A) Periodontal scaling and root planing (D4341, D4342) is allowed once (1) every two (2) years; ¶

(i) A maximum of two (2) quadrants on one date of service is payable, except in extraordinary circumstances supported by documentation; ¶

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

(B) Single implants may count as an additional tooth when billing, the maximum number per quadrant and pocket depth requirements still apply; ¶

(C) Full mouth debridement (D4355) allowed once (1) every two (2) years; ¶

(D) Scaling in the presence of generalized moderate or severe gingival inflammation, full mouth, after dental evaluation (D4346) is allowed once (1) every two (2) years. ¶

(d) Periodontal maintenance (D4910) is allowed once (1) every six (6) months: ¶

(A) Following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three (3) years; and ¶

(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). ¶

(e) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and radiographs; ¶

(13) 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) Periodontal health needs to be stable and supportive of a prosthetic; ¶

(f) For indications and limitations of coverage and dental appropriateness, the Authority may cover reasonable and necessary replacement of medically necessary and dentally appropriated, covered dentures, including those items purchased or in use before the member enrolled with OHP. ¶

(g) Replacement of dentures because of loss due to circumstances beyond the member's control, irreparable damage referring to a specific accident or to a natural disaster/situations involving the provision of the medically necessary and dentally appropriate items when: ¶

(A) There is a change in the member's condition that warrants a new item; ¶

(B) The item is not repairable; ¶

(C) There is coverage for the specific item as identified in Chapter 410, Division 123; ¶

(h) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of a denture may not be covered. ¶

(i) Partial dentures: ¶

(A) The Authority does not approve resin partial dentures (D5211, D5212) 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); and ¶

(E) Are not to be used in lieu of space maintainers. ¶

(i) Replacement of removable partial or complete dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., relin, rebase, repair, tooth replacement), is limited to the following: ¶

(A) Complete dentures once (1) every 10 years, only if medically necessary and dentally appropriate. Coverage is for only one of the following options (not both); ¶

(i) Complete dentures (D5110 and D5120); or ¶

(ii) Immediate dentures (D5130 and D5140). ¶

(B) Partial dentures once (1) every five (5) years, only if medically necessary and dentally appropriate. Coverage is for only one of the following options; ¶

(i) Partial denture resin base (D5211, D5212); or ¶

(ii) Immediate partial denture (D5221, D5222); or ¶

(iii) Interim partial dentures (D5820, D5821); ¶

(C) The five (5) and 10 year limitations apply to the member regardless of the member's OHP or CCO 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. ¶

(E) 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. Exceptions may not be considered in the presence of severe periodontal disease. ¶

(k) 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). ¶

(l) Replacement of all teeth and acrylic on cast metal framework (D5670, D5671) is covered with a PA: ¶

(A) A maximum of once (1) every 10 years, per arch; ¶

(B) When 10 or more years have passed since the original partial denture was delivered; and ¶

(C) Is considered replacement of the partial so a new partial denture shall not be reimbursed for another 10 years. ¶

(m) 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 may not warrant rebasing; ¶

(n) 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 until six (6) months after placement of any complete or immediate denture or any partial 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. ¶

(o) Tissue conditioning: ¶

(A) Is allowed once per denture unit in conjunction with immediate dentures; and ¶

(B) Is allowed once prior to new prosthetic placement. ¶

(13) 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 a CCO, bill medical maxillofacial prosthetics to the CCO; and ¶

(C) For members receiving medical services through FFS, bill the Authority. ¶

(14) Prosthodontics, fixed (CDT codes D6200-D6999): ¶

(a) The Authority does not cover the placement of fixed partial dentures./ ¶

(b) D6100 and D6105 are covered as according to the criteria in Guideline Note 123: ¶

(A) Advanced peri-implantitis with bone loss and mobility, abscess; or ¶

(B) Implant fracture. ¶

(15) 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), refer to Guideline Note 48; ¶

(i) Maxillary labial frenulectomy is not covered until age 12; and ¶

(ii) Not billable if member has received D7963. ¶

(B) Lingual frenectomy (frenulectomy) (D7962), refer to Guideline Note 48 and 139, is not covered until age 12 unless ankyloglossia is interfering with breastfeeding; or ¶

(C) Frenuloplasty (D7963), refer to Guideline Note 48; ¶

(i) Once (1) per lifetime per quadrant; and ¶

(ii) Not billable if member has received D7961. ¶

(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 (D7320, D7321) is reimbursable for EPSDT beneficiaries, and for members who are pregnant or 12 months postpartum. ¶

(16) 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; ¶

(B) The Authority approves the PA request for orthodontic treatment; and ¶

(C) EPSDT qualification for the OHP Orthodontic benefit is determined when: ¶

(i) Dental Appropriateness as demonstrated when the member has a malocclusion; and ¶

(ii) Medical Necessity for the orthodontic treatment is demonstrated when the member meets the automatic qualifying criteria and/or a score of 26 or higher on the Handicapping Labiolingual Deviation (HLD) score index. ¶

(b) Pre-orthodontic treatment examinations (D8660) must be provided by a licensed dentist. ¶

(c) Pre-orthodontic treatment examinations (D8660) do not require PA. Coverage is 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./The imaging required is not to be billed separately. Coverage is: ¶

(A) Once (1) per member, per provider, in a 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 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 or 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, D8091), 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 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) Payment for comprehensive orthodontic treatment includes all appliances, repairs and all follow-up visits. ¶

(h) 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. ¶

(i) 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.// ¶

(i) 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. ¶

(k) Care navigation assistance for members must be made available during transfer of care in situations such as provider changes. ¶

(17) Adjunctive General and Other Services (CDT codes D9000-D9999): ¶

(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 and sedation: ¶

(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 (D9248) is covered for EPSDT beneficiaries as follows: ¶

(i) Limited to members under 13 years of age. Members age 13 and older require PA); ¶

(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) House/extended care facility call (D9410) is limited to 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's or facility's convenience. ¶

(18) Sleep Apnea Services: ¶

(a) Sleep apnea devices and appliances may be placed or fabricated by a general dentist or specialist although they are considered medical services; ¶

(b) Bill the Authority or CCO for sleep apnea services using medical billing codes on the professional claim form unless guidance specifies otherwise; ¶

(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 criteria), and is replaceable at the end of the five (5) year reasonable useful lifetime; ¶

(d) The Authority does not cover adjustments for dental sleep apnea appliances (D9948). The adjustments are considered part of the normal follow-up care within the first 90 days after provision of the device, and are included as services of (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. ¶

(19) Dental care access standards for pregnant members: ¶

(a) Dental care benefits for pregnant members shall continue for 12 months following the end of pregnancy; and ¶

(b) For additional dental care benefit for members who are pregnant or 12 months postpartum, refer to OAR 410-123-1510. ¶

(20) 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) Not all services included in the Current Dental Terminology (CDT) codebook are covered by the Authority; / ¶

(c) These services must not be listed as combined with another procedure; and ¶

(d) Under the Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS) issued regulations in 2024 for payment for dental services that are inextricably linked to certain covered medical services, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements,

valvuloplasty procedures, and treatments for head and neck cancers. ¶

(21) 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 (D0601-D0603); ¶

(d) Curettage and root planing - per tooth is not eligible for separate reimbursement unless the service is significant and separately identifiable; ¶

(e) Diagnostic casts (D0470); ¶

(f) Direct pulp cap (D3110); ¶

(g) Discing; ¶

(h) Dressing change; ¶

(i) Electrosurgery; ¶

(j) Equilibration; ¶

(k) Gingival curettage - per tooth (D4220); ¶

(l) Gingival irrigation (D4921); ¶

(m) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212); ¶

(n) Indirect pulp cap; ¶

(o) Local anesthesia; ¶

(p) Medicated pulp chambers; ¶

(q) Occlusal adjustments (D9951, D9952); ¶

(r) Occlusal analysis; ¶

(s) Odontoplasty; ¶

(t) Oral hygiene instruction (D1330); ¶

(u) Periodontal charting, probing; ¶

(v) Post removal; ¶

(w) Polishing fillings; ¶

(x) Post extraction treatment for alveolaritis (dry socket treatment) if done by the provider of the extraction; ¶

(y) Pulp vitality tests (D0460); ¶

(z) Smooth broken tooth; ¶

(aa) Special infection control procedures; ¶

(bb) Surgical procedure for isolation of tooth with rubber dam (D3910); ¶

(cc) Surgical splint (D5988); ¶

(dd) Surgical stent (D5982); ¶

(ee) Suture removal; and ¶

(ff) Teledentistry (D9995, D9996). ¶

(22) 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 (See Prioritized List Guideline Note 169); ¶

(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

RULE SUMMARY: This rule was amended for benefit clarity.

CHANGES TO RULE:

410-123-1262

~~Dental Administration of Vaccines~~

(1) Dental administration of vaccines must be carried out in compliance with Oregon Board of Dentistry OARs 818-012-0006 and 818-012-0007, OHA Medical/Surgical OAR 410-130-0255 and Vaccines for Children (VFC) - OHA Division 46, OARs 333-046-0110 through 333-046-0130.¶

~~(2) Requirements for vaccine administration: The Authority covers immunization counseling (D1301) when the vaccine is not administered on the same date of service. ¶~~

~~(3) Provider must: ¶~~

~~(a) Be registered with the ALERT Immunization Information System (IIS) at a minimum as a query user; ¶~~

~~(b) Stay current with recommended immunization schedules by keeping up to date on immunization science and protocols and understand the risks, benefits, contraindications, and potential adverse effects of vaccines; ¶~~

~~(c) Review the member's vaccine and medical history; ¶~~

~~(d) Explain to members which immunizations are recommended based on the member's age, medical history, and risk factors and discuss the benefits of vaccination in preventing serious diseases; ¶~~

~~(e) Counsel with the member what signs and symptoms of potential adverse effects may be and on when medical attention may be needed, addressing questions and concerns; ¶~~

~~(f) Provide information to the member about where to obtain the vaccine(s); and ¶~~

~~(g) Refer the member to their primary care provider for administration of the vaccine. ¶~~

~~(4) The Authority encourages providers to take continuing education courses related to immunizations and to regularly review the OHA Immunization Information for Dentists website for best practices, educational resources, and additional information at~~

~~[https://www.oregon.gov/oha/PH/PreventionWellness/VACCINESIMMUNIZATION/IMMUNIZATIONPROVIDERRESOURCES/Pages/Dentists.aspx](https://www.oregon.gov/oha/PH/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Pages/Dentists.aspx). ¶~~

~~(5) Requirements for vaccine administration: ¶~~

~~(a) The licensed provider must have completed a course of training approved by the Oregon Board of Dentistry; ¶~~

~~(b) Licensed provider must register in ALERT; ¶~~

~~(c) Vaccines must be administered in accordance with the Model Immunization Protocols approved by the Authority; and ¶~~

~~(ed) The dentist must not delegate administration of vaccines to another person. ¶~~

~~(36) Procedures for licensed providers administering vaccines: ¶~~

~~(a) Must report to ALERT within fourteen (14) days of administration; ¶~~

~~(A) Follow the Authority approved Model Immunization Protocols for immunization administration and treatment of severe adverse events following an administration. The Authority Model Immunization Protocols are located at:~~

~~<https://www.oregon.gov/oha/PH/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Pages/provresources.aspx> (see Vaccine 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 system outlined in~~

~~<https://www.oregon.gov/oha/PH/PreventionWellness/VaccinesImmunization/alert/Pages/EnrollNewClinic.aspx>; ¶~~

~~(b) Report adverse events within ten (10) business days to the: ¶~~

~~(A) Vaccine Adverse Events Reporting System (VAERS); ¶~~

~~(B) Oregon Board of Dentistry; and ¶~~

~~(C) Primary Care Provider (PCP) identified by the member. If the member does not have a PCP, providers must: ¶~~

~~(i) Provide the member with a copy of vaccination administration 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 member's record. ¶~~

~~(c) Dentists or designated staff must: ¶~~

~~(A) Provide Vaccine Information Statements (VIS) to the member or legal representative with each dose of vaccine covered by these forms; ¶~~

~~(B) Document that the member or legal representative has read, or has had read to them, the information~~

provided and that any questions are answered prior to the administration of the vaccine. The VIS provided must be the most current version; and ¶

(C) Document in the 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 Authority ALERT Immunization System; and ¶

(vii) Date of publication of the VIS; and Date the VIS was provided. ¶

(47) Vaccines are billed using CPT codes on a Professional claim form (CMS 1500) found in the Professional Billing Instructions and the Medical-Surgical Services Provider Guide located at:

<https://www.oregon.gov/oha/HSD/OHP/Tools/Medical-Surgical%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 criteria; ¶

(B) All vaccines for this age group and for conditions covered by the VFC program must be obtained through the VFC program; and ¶

(C) The Authority does not reimburse providers for the administration or purchase of privately purchased vaccines if the vaccine may have been obtained through the VFC program. ¶

(b) Non-EPSDT beneficiaries: Billing providers must use standard professional claim form billing procedures for adults and for any vaccine that is not part of the VFC program; and ¶

(c) For information about the VFC program or to enroll as a VFC provider, contact the Public Health Immunization Program. The Oregon VFC program website ~~can be located at~~ is:

<https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/IMMUNIZATIONPROVIDERRESOURCES/VFC/Pages/index.aspx>. ¶

(58) The Authority reimburses only for the administration, not the serum, of vaccines available for free through the VFC Program. Refer to the Current Oregon Immunization Program State-Supplied Vaccine Billing Codes table in the Immunization Billing Resources section for a list of vaccines provided through the VFC Program. ¶

(69) To receive reimbursement for vaccine administration, VFC program providers must bill the Authority with the appropriate vaccine coding; ¶

(a) CPT code and the modifier SL; ¶

~~7~~; or ¶

(b) CDT code. ¶

(10) FFS providers may bill the Authority directly for vaccines provided to members. Providers may bill the plans directly, as appropriate to member plan enrollment, for the administration of VFC vaccines if the member is enrolled in a ~~Managed Care Entity (MCE)~~ CCO. Medicaid and Children's Health Insurance Program (CHIP) are not considered the "payer of last resort" for administration of VFC vaccines.

Statutory/Other Authority: ORS 679.543, 414.065, HB 2220 (2019 Regular Session)

Statutes/Other Implemented: ORS 414.065

RULE SUMMARY: This rule was amended to clarify that synchronous and asynchronous teledentistry are not eligible for separate reimbursement.

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 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 member being present in real time;¶

(c) Remote 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 apply to teledentistry services in the same manner as other services.¶

(3) Billing Provider Requirements, as referenced in OAR 410-120-1990:¶

(a) Dentists providing Medicaid services must be licensed to practice dentistry within the State of Oregon or within the contiguous area of Oregon and must be enrolled as 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 (OHA) Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records (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 (1) of this rule;¶

(C) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of member health information or records (whether oral or recorded in any form or medium) to unauthorized individuals; and¶

(D) Maintaining clinical and financial documentation related to telehealth services as required in OAR 410-120-1360 and OAR 410-120-1990.¶

(c) A member receiving services through teledentistry must be notified of the right to receive interactive communication with the distant dentist and must receive an interactive communication with the distant dentist upon request;¶

(d) The member's chart documentation must reflect notification of the right to interactive communication with the distant site dentist; and¶

(e) A 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 410-120-1990, other types of telecommunications such as telephone calls, images transmitted via facsimile machines, and electronic mail are not covered;¶

(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) Teledentistry - synchronous (D9995) and Teledentistry - asynchronous (D9996) are not eligible for separate reimbursement. ¶

(b) The dentist who completes diagnosis and treatment planning and the oral evaluation also documents these services using the traditional Current 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)c) 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 must meet all criteria of the CDT code billed.

Statutory/Other Authority: ORS 679.543, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1490

RULE SUMMARY: This rule was amended for clarity.

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 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). ¶

(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. ¶

(3) Hospital dentistry is intended for the following members: ¶

(a) Age three (3) and younger that have extensive dental needs; ¶

(b) Per OAR Chapter 410, Division 151, EPSDT beneficiaries are covered with the following conditions: ¶

(A) Acute situational anxiety, fearfulness, extreme uncooperative behavior; ¶

(B) An inability to communicate, such as a member with developmental or intellectual disability or a member who is pre-verbal; ¶

(C) A need for general anesthesia (or IV conscious sedation) to protect the developing psyche; ¶

(D) Sustained extensive orofacial or dental trauma; or ¶

(E) Physical, mental, or medically compromising conditions. ¶

(c) 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) Sustained extensive orofacial or dental trauma; or ¶

(C) A medically fragile 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); or ¶

(D) Have complex medical needs, contractures or other significant medical conditions potentially making the dental office setting unsafe for the member. ¶

(4) Hospital dentistry is not intended for: ¶

(a) Member convenience (Refer to OAR 410-120-1200); ¶

(b) A healthy, cooperative member with minimal dental needs; ¶

(c) Members who have successfully received previous dental treatments in office settings; or ¶

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

(5) The following information must be included in the member's dental record: ¶

(a) Informed consent: Member, 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, including the following considerations: ¶

(A) Alternative behavior management modalities; ¶

(B) Member's dental needs; ¶

(C) Quality of dental care; ¶

(D) Quantity of dental care; ¶

(E) Member's emotional development; and ¶

(F) Member's physical considerations. ¶

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

(d) The Authority or ~~Managed Care Entity (MCE)~~ CCO may require additional documentation when reviewing requests for Prior authorization (PA) of hospital dentistry services (Refer to OAR 410-123-1160); ¶

(e) The Authority shall require clinical documentation explaining why the dentist did not complete the previous treatment plan, if the dentist 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: 410-123-1510

RULE SUMMARY: This rule was amended for clarity and readability.

CHANGES TO RULE:

410-123-1510

Additional Dental Care Benefits for Pregnant Members ¶

- (1) This rule sets forth the access standards for dental care for ~~pregnant~~ members who ~~receive Oregon Health Plan (OHP) benefits through the fee-for-service (FFS) delivery system.~~ pregnant or 12 months postpartum. ¶
- (2) Pregnant members ~~shall~~ must be seen, treated in person or via teledentistry for ~~an~~ the following OHP-covered service and within the following time frames: ¶
- (a) ~~For~~ Emergency dental care: within 24 hours; ¶
- (b) ~~For~~ urgent dental care: within one (1) week; ¶
- (c) ~~For~~ routine dental care: within four (4) weeks, unless there is a documented special clinical reason that ~~would~~ may make access ~~longer than four weeks appropriate~~ it appropriate to be seen or treated beyond this time frame; ¶
- (d) ~~For~~ initial dental screening or examination: within four (4) weeks. ¶
- (3) ~~A~~ The following additional ~~D~~ dental ~~S~~ services are available to pregnant members if authorized as medically/~~D~~ or dentally ~~N~~ necessary due to the pregnancy. ~~Additional services include:~~ ¶
- (a) ~~Additional p;~~ ¶
- (a) 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) Alveoloplasty not in conjunction with extractions. ¶
- (4) Nothing in this rule obligates a pregnant member ~~who receives dental care through the FFS delivery system to accept an offered appointment.~~ ¶
- (5) ~~Dental care benefits for pregnant members will continue 12 months following the end of the pregnancy/to accept an offered service.~~

Statutory/Other Authority: ORS 413.042, ORS 414.065

Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1620

RULE SUMMARY: This rule was amended for clarity, readability, and to remove unnecessary information, or duplicative information that exists elsewhere in the rule.

CHANGES TO RULE:

410-123-1620

~~Pertaining to Coding~~Coding and Documentation

(1) ~~The Authority requires providers must~~ use the standardized code sets adopted by the Health Insurance Portability and Accountability Act (HIPAA) and the Centers for Medicare and Medicaid Services (CMS), ~~and by the Chapter 410 Division 120 rules.~~

(2) Unless otherwise directed in this Chapter 410, Division 123 rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided.

~~(3) National Code Set issuance alone may not be construed as coverage or a covered service by the Authority.~~

(3) The Authority or designee may review or audit providers' claims before or after payment in accordance with OARs 410-120-1396, 410-120-1395, or 410-120-1397 and payments may be denied or subject to recovery if the review or audit determines the care, service or item;

(a) Was not provided in accordance with this Chapter 410 Division 123, or Chapter 410 Division 120 rules; or

(b) Does not meet the criteria for quality or appropriateness of payment.

(4) 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 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~~For procedures are covered under the Authority's medical surgical program, (refer to Chapter 410, Division 130).

(4) Diagnosis codes:

~~(a) International Classification of Diseases 10th Clinical Modification (ICD-10-CM) diagnosis codes are:~~

~~(a) 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~~Are required for medical surgical program services submitted on a professional claim form (refer to Chapter 410, Division 130).

(5) Ancillary codes:

~~(a) Services must be medically necessary and dentally appropriate:~~

(a) For medication and deep sedation are provided for in hospitalization, for conditions appearing must be above the funding line of the Prioritized List; and are subject to the Prioritized List's ancillary guideline notes.

~~(b) Must be medically necessary and dentally appropriate. Some ancillary codes are not eligible for separate reimbursement (Refer to OAR 410-123-1260 for more detail on codes not to be billed separately).~~

~~(c) Approved ancillary codes (subject to OAR 410-123-1260) for all members are as follows:~~

~~(A) D7990-Em.~~

~~(c) Ancillary codes covered by Medicaid are listed in Code Group 6060 and can be found by referency~~Tracheotomy;

~~(B) D9211-Ring~~ <https://data.oregonalblockanesthesia.gov/>

~~(C) D9212-Trigeminal division block anesthesia;~~ [gov/Health-Human-Services/Group-6060-Ancillary-Services/fq2m-i6ix/about_data](https://data.oregonalblockanesthesia.gov/Health-Human-Services/Group-6060-Ancillary-Services/fq2m-i6ix/about_data).

(7) Records and documentation:

~~(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~~

physiTo be eligible for reimbursement, providers must comply with all dental services rules, criteria, billing, and limits in this Chapter 410 Division 123 and Chapter 410 Division 120 and shall maintain records that fully support the extent of the service(s) and all procedure codes for which payment is requested.

(b) Providers must maintain clinical, financial; and

~~(I) D9997-Dental case management, patients with special health care needs.~~

~~(d) D9248-(non-intravenous conscious sedation) is covered for EPSDT beneficiaries as follows: other records,~~

capable of being audited or reviewed, as required under Chapter 410 Division 120 and Chapter 410 Division 141;

¶

~~(A) Limited to Providers must keep records four (4) times per year for members age 13 and younger; ¶~~

~~(B) Includes pay seven (7) years. Providers contracted with a CCO must meet for monitoring and Nitrous Oxide the record retention requirements in OAR 410-141-3520; and ¶~~

~~(C) Require Providers must use of multiple agt have in each client's to receive payment. ¶~~

~~(e) D9410—(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 medical record a detailed description of the clinical indications and dental necessity of the dental service(s), including, but not limited to, the tooth number(s), surface(s), pocket depth(s), and radiographs. The provider must annotate the clinical record each time a service is provided outside of the office for the provider or facilities' convenience and sign and date the record prior to submitting a claim for payment.~~

Statutory/Other Authority: ORS 413.042, 414.065

Statutes/Other Implemented: ORS 414.065