

# Dental Services

## Rulebook

**Includes:**

- 1) Table of Contents
- 2) Current Update Information (changes since last update)
- 3) Other Provider Resource Information
- 4) Complete set of Dental Services Administrative Rules

**DEPARTMENT OF HUMAN SERVICES  
MEDICAL ASSISTANCE PROGRAMS  
DIVISION 123  
DENTAL SERVICES**

Update Information (most current Rulebook changes)

Information on Other Provider Resources

**Administrative Rules:**

410-123-1000	Eligibility
410-123-1060	Definition of Terms
410-123-1085	Client Copayments for Oregon Health Plus Benefit
410-123-1100	Services Reviewed by the Division of Medical Assistance Programs (DMAP)
410-123-1160	Prior Authorization
410-123-1200	Services Not To Be Billed Separately
410-123-1220	Services Not Funded on the Health Services Commission's Prioritized List of Health Services
410-123-1230	Buy-Ups
410-123-1240	The Dental Claim Invoice
410-123-1260	Dental Exams, Diagnostic and Procedural Services
<i>Table 123-1260-1 Covered Dental Services</i>	
410-123-1490	Hospital Dentistry

410-123-1540	Citizen/Alien-Waived Emergency Medical
410-123-1600	Managed Care Organizations
410-123-1620	ICD-9-CM
410-123-1640	Prescriptions
410-123-1670	OHP Standard Limited Emergency Dental Benefit

# Dental Services Program Rulebook

## Update Information

January 1, 2008

The Division of Medical Assistance (DMAP) updated this Rulebook with the following administrative rule revisions:

**AMENDED:** 410-123-1000, 410-123-1060, 410-123-1100,  
410-123-1160, 410-123-1200, 410-123-1220,  
410-123-1240, 410-123-1260, 410-123-1490,  
410-123-1620, and 410-123-1670

**REPEALED:** 410-123-1040

DMAP made changes to clarify current policies and procedures to ensure these rules are not open to interpretation by the provider or outside parties and to help eliminate confusion possibly resulting in non-compliance.

The clarification also helps facilitate provider compliance with payment methodology, service coverage and limitations, prior authorizations, and billing requirements.

Text is revised to improve readability and take care of necessary “housekeeping” corrections.

The Table of Contents is updated.

If you have questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697.

## Other Provider Resources

DMAP has developed the following additional materials to help you bill accurately and receive timely payment for your services.

---

### ■ Supplemental Information

The Dental Services Supplemental Information booklet contains important information not found in the rulebook, including:

- ✓ Prior authorization information
- ✓ Billing instructions
- ✓ Information on required forms and claims screening
- ✓ Electronic claims information
- ✓ Other helpful information not found in the rulebook

Be sure to download a copy of the Dental Services Supplemental Information booklet at:

<http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.html>

Note: DMAP revises the supplement booklet throughout the year, without notice. Check the Web page regularly for changes to this document.

### ■ Provider Contact Booklet

This booklet lists general information phone numbers, frequent contacts, phone numbers to use to request prior authorization, and mailing addresses.

Download the Provider Contact Booklet at:

[http://www.oregon.gov/DHS/healthplan/data\\_pubs/add\\_ph\\_conts.pdf](http://www.oregon.gov/DHS/healthplan/data_pubs/add_ph_conts.pdf)

### ■ Other Resources

We have posted other helpful information, including provider announcements, at:

[http://www.oregon.gov/DHS/healthplan/tools\\_prov/main.shtml](http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml)

---

### Remember to register for eSubscribe

When you register for our FREE subscription service, you will be notified by email whenever the content changes on the Web pages that you designate. Just click on the eSubscribe link on individual OHP pages, or subscribe to multiple pages from the master list by choosing the eSubscribe link above. Esubscribe at:

<http://www.oregon.gov/DHS/govdelivery.shtml>

## **410-123-1000 Eligibility**

(1) Before providers bill the Division of Medical Assistance Programs (DMAP) or any Oregon Health Plan (OHP) Prepaid Health Plan (PHP) for services, eligibility must be verified before providing any service. It is the responsibility of the provider to verify the client's eligibility. DMAP will not pay for services provided to an ineligible client even if services were authorized. Always check the client's DMAP Medical Care ID or call the Automated Information System (AIS) to verify eligibility.

(2) The DMAP Medical Care ID guarantees eligibility only for the time period listed on the ID. Refer to the front of the DMAP Dental Services rules for instructions on reading a DMAP Medical Care ID.

(3) Providers must follow DMAP rules in effect on the date of service. All DMAP rules are intended to be used in conjunction with the DMAP General Rules (chapter 410, division 120), the OHP Administrative Rules (chapter 410, division 141), Pharmaceutical Services Rules (chapter 410, division 121) and other relevant DMAP OARs applicable to the service provided, where the service is delivered, and the qualifications of the person providing the service including the requirement for a signed provider enrollment agreement. (4) Billing of Third Party Resources:

(a) A third party resource (TPR) is an alternate insurance resource, other than DMAP, available to pay for medical services and items on behalf of Medical Assistance Program clients. Any alternate insurance resource must be billed before DMAP or any OHP PHP can be billed. Indian Health Services or Tribal facilities are not considered to be a TPR pursuant to General Rules (OAR 410-120-1280);

(b) If other health insurance is named in the "Managed Care/TPR" section of the client's DMAP Medical Care ID, it means that the client has other resources that must be billed prior to billing any OHP PHP or DMAP. (5) Fabricated Prosthetics: If a dentist or denturist provides an eligible client with fabricated prosthetics that require the use of a dental laboratory, and the fabrication is expected to extend beyond

the period of eligibility listed on the client's DMAP Medical Care ID, the dentist/denturist should use the date of final impression as the date of service, but also indicate the date of delivery. This is the only exception to General Rules (OAR 410-120-1280). All other services must be billed using the date the service was provided.

(6) Treatment Plans: Being consistent with established dental office protocol and the standard of care within the community, scheduling of appointments is at the discretion of the dentist. The agreed upon treatment plan established by the dentist and patient will establish appointment sequencing. Possession of a DMAP Medical Care ID does not entitle a client to any services or consideration not provided to all clients.

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08

## **410-123-1060 Definition of Terms**

(1) Central Nervous System Anesthesia -- An induced controlled state of unconsciousness or depressed consciousness produced by a pharmacologic method. Refer to Oregon Board of Dentistry administrative rules (OAR Chapter 818 - Division 026) for further details.

(a) Conscious Sedation – An induced controlled state of minimally depressed consciousness in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

(b) Deep Sedation – An induced controlled state of depressed consciousness in which the patient experiences a partial loss of protective reflexes, as evidenced by the inability to respond purposefully either to physical stimulation or to verbal command but the patient retains the ability to independently and continuously maintain an airway.

(c) General Anesthesia –An induced controlled state of unconsciousness in which the patient experiences complete loss of protective reflexes, as evidenced by the inability to independently maintain an airway, the inability to respond purposefully to physical stimulation, or the inability to respond purposefully to verbal command.

(d) Nitrous Oxide Sedation - An induced controlled state of minimally depressed consciousness, produced solely by the inhalation of a combination of nitrous oxide and oxygen, in which the patient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

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

OAR 410-120-1210 provides a complete description of limited emergency coverage pertaining to the CAWEM benefit package.

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

(4) Dental Hygienist -- A person licensed to practice dental hygiene pursuant to State law.

(5) Dental Hygienist with Limited Access Permit (LAP) -- A person licensed to practice dental hygiene with a LAP and within the scope of a LAP pursuant to State law.

(6) Dental Services -- Services provided within the scope of practice as defined under State law by or under the supervision of a dentist or dental hygienist, or denture services provided within the scope of practice as defined under State law by a denturist.

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

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

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

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community, Evidence Based Medicine and professional standards of care as effective;

(c) Not solely for the convenience of a OHP Member or a Provider of the service; and

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a Division of Medical Assistance Program (DMAP) Member.

(9) Dentist -- A person licensed to practice dentistry pursuant to State law.

(10) Denturist -- A person licensed to practice denture technology pursuant to State law.

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

(12) Emergency Services:

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

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

(A) Acute infection;

(B) Acute abscesses;

(C) Severe tooth pain;

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

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

(c) The treatment of an emergency dental condition is limited only to covered services. DMAP recognizes that some non-covered services may meet the criteria of treatment for the emergency condition, however this rule does not extend to those non-covered services. Routine dental treatment or treatment of incipient decay does not constitute emergency care;

(d) The OHP Standard Benefit Package includes a limited emergency dental benefit. Refer to OAR 410-123-1670.

(13) Hospital Dentistry Dental services normally done in a dental office setting, but due to specific client need (as detailed in OAR 410-123-1490) are provided in an ambulatory surgical center, inpatient, or outpatient hospital setting under general anesthesia (or IV conscious sedation, if appropriate).

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

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08

## **410-123-1085 Client Copayments for Oregon Health Plus Benefit**

(1) OHP Plus: Copayments may be required for certain services:

(a) Clients enrolled in a Dental Care Organization are exempt from copayments. Refer to OAR 410-120-1230 for specific details;

(b) Refer to Table 123-1260-1 for a list of individual services covered under the OHP Plus Dental Benefit and copayments for individual services.

(2) OHP Standard:

(a) Clients eligible for OHP Standard are exempt from copayments. Refer to OAR 410-120-1230 for specific details;

(b) Refer to Table 123-1670-1 for a list of individual services covered under the OHP Standard Limited Emergency Dental Benefit.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-123-1100 Services Reviewed by the Division of Medical Assistance Programs (DMAP)**

(1) The Division of Medical Assistance Programs (DMAP) will not give prior authorization (PA) for payment when the prognosis is unfavorable, the treatment impractical, or a lesser-cost procedure would achieve the same ultimate results.

(2) Consultants: For certain services and billings, DMAP contracts with a general practice consultant and an oral surgery consultant for professional review before PA of payment. DMAP will deny PA if the consultant decides that the clinical information furnished does not support the treatment or services.

(3) By Report Procedures: Request for payment for dental services listed as By Report, or services not included in the procedure code listing must be submitted with a full description of the procedure, including relevant operative or clinical history reports and/or radiographs. Payment for By Report procedures will be approved in consultation with a DMAP dental consultant.

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

(a) Before issuing PA;

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

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

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08

## **410-123-1160 Prior Authorization**

(1) Prior authorization (PA) for services and supplies listed in the Dental Services administrative rules are intended for clients who are not enrolled in a Dental Care Organization (DCO). Contact the client's DCO for their policy governing PA requirements.

(2) Covered services requiring PA from the Division of Medical Assistance Programs (DMAP) for clients receiving dental benefits under fee-for-service (FFS) are:

(a) Crowns;

(b) Complete dentures;

(c) Immediate dentures;

(d) Partial dentures;

(e) Denture repairs; and

(f) Orthodontics (when covered pursuant to OAR 410-123-1260).

(3) Hospital Dentistry – Refer to OAR 410-123-1490 for PA for routine (non-emergency) dental services performed in an Ambulatory Surgical Center (ASC), outpatient or inpatient setting. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(4) Life-threatening Emergencies - PA for outpatient or inpatient services is not required for any life-threatening emergencies. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(5) Oral Surgical Services – PA is required for oral surgical services performed in an Ambulatory Surgical Center (ASC), outpatient or inpatient hospital setting and related anesthesia. Refer to OAR 410-

123-1260(15) and the current Medical Surgical Services administrative rules (OAR 410-130-0200) for information.

(6) Maxillofacial Surgeries - PA for some maxillofacial surgeries may be required. Refer to the current Medical Surgical Services administrative rules for information (OAR 410-130-0200).

(7) DMAP will provide PA for services when:

(a) The prognosis is favorable;

(b) The treatment is practical;

(c) The services are dentally appropriate; and

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

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

(9) Treatment Justification: DMAP 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:

(A) Readable copies;

(B) Mounted or loose;

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

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

(E) If digital x-ray, they must be of photo quality.

(b) Do not send in radiographs unless required by the Dental Services administrative rules or requested during the PA process.

(10) Requests to DMAP for PA must be made through the DMAP Dental Program Coordinator in writing on an ADA form, listing the specific services requested. No phone calls requesting PA will be accepted.

(11) Upon approval of the request for payment, a nine-digit PA number will be entered on the requesting form and the form will be returned to the treating provider. Claims cannot be paid without this PA number.

(12) DMAP will issue a decision on PA requests within 30 days of receipt of the request.

(13) For certain services and billings, DMAP will seek a general practice consultant or an oral surgery consultant for professional review before PA. DMAP will deny PA if the consultant decides that the clinical information furnished does not support the treatment of services.

(14) PA for clients receiving services through a DCO for services other than hospital dentistry:

(a) Contact the client's DCO for PA requirements for individual services and/or supplies listed in the Dental Services administrative rules. DCOs may not have the same PA requirements for dental services;

(b) If a client is enrolled in a Fully Capitated Health Plan (FCHP) or in a Physician Care Organization (PCO) and is responsible for hospital services, the FCHP or PCO may require PA for Ambulatory Surgical Center (ASC), outpatient or inpatient hospital dental services. It is the responsibility of the provider to check with the FCHP for any required authorization prior to the service being rendered;

(c) If a client is enrolled in a DCO and is FFS for medical, DMAP requires PA for ASC, outpatient or inpatient hospital dental services.

It is the responsibility of the provider to contact DMAP for PA prior to the service being rendered;

(d) If a client is enrolled in a DCO and is assigned to a Primary Care Manager (PCM) through FFS, the client must have a referral from the PCM prior to any hospital service being approved by DMAP.

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08

## **410-123-1200 Services Not To Be Billed Separately**

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

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

(a) Alveolectomy/Alveoloplasty in conjunction with extractions;

(b) Cardiac and other monitoring;

(c) Curettage and root planing -- per tooth;

(d) Diagnostic casts;

(e) Dietary counseling;

(f) Direct pulp cap (exception: direct pulp cap is covered separately for OHP Standard clients; the Standard benefit plan does not cover restorations);

(g) Discing;

(h) Dressing change;

(i) Electrosurgery;

(j) Equilibration;

(k) Gingival curettage -- per tooth;

(l) Indirect pulp cap;

(m) Local anesthesia;

- (n) Medicated pulp chambers;
- (o) Occlusal adjustments;
- (p) Occlusal analysis;
- (q) Odontoplasty;
- (r) Oral hygiene instruction;
- (s) Periodontal charting, probing;
- (t) Polishing fillings;
- (u) Post extraction treatment for alveolaritis (dry socket treatment) if done by the provider of the extraction;
- (v) Pulp vitality tests;
- (w) Smooth broken tooth;
- (x) Special infection control procedures;
- (y) Surgical procedure for isolation of tooth with rubber dam;
- (z) Surgical splint;
- (aa) Surgical stent; and
- (bb) Suture removal.

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08

## **410-123-1220 Services Not Funded on the Health Services Commission's Prioritized List of Health Services**

(1) Table 123-1260-1 contains all covered dental services. This table is subject to change if there are funding changes to the Health Services Commission's (HSC) List of Prioritized Services (posted on DHS' website at:

[http://egov.oregon.gov/DAS/OHPPR/HSC/current\\_prior.shtml](http://egov.oregon.gov/DAS/OHPPR/HSC/current_prior.shtml)). In the event of an alleged variation between a Division of Medical Assistance Program (DMAP)-listed code and a national code, DMAP will apply the national code in effect on the date of request or date of service.

(2) The following general categories of Dental Services are not included/funded on the HSC List and are not covered for any client. Several of these services are considered "cosmetic" in nature (i.e., done for the sake of appearance):

(a) Desensitization;

(b) Implant and implant services;

(c) Mastique or veneer procedure;

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

(e) Overhang removal;

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

(g) Temporomandibular Joint Dysfunction treatment; and

(h) Tooth bleaching.

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08

## **410-123-1230 Buy-Ups**

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

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

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

(2) For example, an additional client payment to obtain a gold crown (not covered) instead of the stainless steel crown (covered); an additional client payment to obtain eyeglass frames not on the DMAP or plan contract. If a client wants to purchase a non-covered service or item, they must be responsible for full payment. DMAP or plan payment for a covered service cannot be credited toward the non-covered service.

(3) Buy-ups are prohibited. Refer to General Rules (OAR 410-120-1350) for specific language on buy-ups.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-123-1240 The Dental Claim Invoice**

(1) The Division of Medical Assistance Programs (DMAP) will only accept claims for professional dental services, in the following formats (Refer to the Dental Supplemental Guide for additional information):

(a) Electronic claims:

(A) The "837" dental claim;

(B) The "835" professional claim for services (identified in OAR 410-123-1260) which are billed as medical;

(C) Submission of an electronic claim directly or through a Billing Agent must comply with the DHS Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et.seq;

(b) Paper claims:

(A) American Dental Association (ADA) paper claims (2006 version only);

(B) CMS-1500 paper claims (8/05 version only) for services (identified in OAR 410-123-1260) which are billed as medical.

(2) Effective August 1, 2005, claims received by DMAP that are not in the correct format will be returned to the provider unprocessed.

(3) The provider will be responsible for making corrections and submitting a valid claim in accordance with these rules.

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08

## **410-123-1260 Dental Exams, Diagnostic and Procedural Services**

- (1) Refer to OAR 410-123-1160 for information regarding dental services requiring prior authorization (PA) and refer to Table 123-1260-1 for requirements to submit surgical reports as shown by “BR” (By Report). Procedure codes listed in Table 123-1260-1 are subject to change by the American Dental Association (ADA) without notification.
- (2) Services funded on the Health Services Commission (HSC) Prioritized List of Health Services may change and may not be immediately reflected in OARs 410-123 until the following rule change period.
- (3) The client's records must include appropriate documentation to support the service and level of care rendered.
- (4) Dental services that are not dentally appropriate as defined in OAR 410-123-1060, or are for the convenience of the client or practitioner, are not covered.
- (5) Restorative, periodontal and prosthetic treatments must be consistent with the prevailing standard of care and documentation must be included in the client's charts to support the treatment. Restorative, periodontal and prosthetic treatments are limited as follows:
  - (a) When prognosis is unfavorable;
  - (b) When treatment is impractical;
  - (c) Until rampant progression of caries is arrested;
  - (d) Until a period of adequate oral hygiene and periodontal stability is demonstrated; periodontal health needs to be stable and supportive of a prosthetic;
  - (e) A lesser-cost procedure would achieve the same ultimate result; or
  - (f) The treatment has specific limitations outlined in this rule.

(6) Exams:

(a) The Division of Medical Assistance Programs (DMAP) will reimburse exams (billed as D0120, D0150, D0160 or D0180) by the same practitioner once every twelve months;

(b) For each emergent episode, use D0140 for the initial exam. Use D0170 for related dental follow-up exams;

(c) Oral exams are not covered when provided by a medical practitioner unless the practitioner is an oral surgeon.

(7) Radiographs:

(a) DMAP will reimburse for routine radiographs once every 12 months;

(b) DMAP will reimburse for panoramic (D0330) or intraoral complete series (D0210) once every five years, but both cannot both be done within the five-year period;

(c) Clients must be a minimum of six years for billing code D0210. For clients under age six, radiographs may be billed separately every 12 months as follows:

(A) D0220 -- once;

(B) D0230 -- a maximum of five times;

(C) D0270 -- a maximum of twice, or D0272 once.

(d) The minimum standards for payment of intraoral complete series are:

(A) For clients age six through 11- a minimum of 10 periapicals and two bitewings for a total of 12 films;

(B) For clients ages 12 and older - a minimum of 10 periapicals and four bitewings for a total of 14 films.

(e) If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), DMAP will pay for the complete series;

(f) DMAP will reimburse bitewing radiographs for routine screening once every 12 months;

(g) Additional films may be covered if dentally or medically appropriate, e.g., fractures (Refer to OAR 410-123-1060 and 410-120-0000);

(h) If DMAP determines the number of radiographs excessive, payment for some or all radiographs of the same tooth or area may be denied:

(i) DMAP will reimburse a maximum of six radiographs for any one emergency;

(j) The exception to these limitations is if the client is new to the office or clinic and the office or clinic was 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 client's records;

(k) Digital radiographs, if printed, should be on photo paper to assure sufficient quality of images.

#### (8) Preventive Services:

(a) Prophylaxis -- Limited to once every 12 months. Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, medications or other medical treatments or conditions, severe periodontal disease, rampant caries and/or for persons with disabilities who cannot perform adequate daily oral health care;

(b) Topical Fluoride Treatment -- Limited to once every 12 months. Additional topical fluoride treatments may be available, up to a total of 4 treatments within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for the following clients:

(A) With high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;

(B) Who are pregnant with a high-risk oral condition(s) limited to periodontal disease or rampant caries;

(C) With physical disabilities that cannot perform adequate, daily oral health care;

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

(E) Who are six years old or younger with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.

(c) Topical fluoride varnish treatments by medical practitioners:

(A) Are covered as part of a medical visit for those high-risk young children that do not have access to a dental practitioner;

(B) Are limited to children six years old and younger in accordance with the limitations detailed in OAR 410-123-1260(8)(b) herein;

(C) Are billed on the CMS-1500 form, using the appropriate CDT code (D1206 – Topical Fluoride Varnish);

(D) An oral screening by a medical practitioner is not a separate billable service and is included in the office visit;

(d) Sealants:

(A) Are covered for permanent molars only for children 15 or younger;

(B) Are limited to one treatment per tooth every five years except for visible evidence of clinical failure;

(e) Topical fluoride varnish and/or sealants by Dental Hygienists in limited access locations:

(A) For clients who receive services on an open-card/fee-for-service basis:

(i) Are reimbursed by DMAP based on the physician fee schedule in accordance with the limitations detailed in OAR 410-123-1260(8)(b) and (d); and

(ii) As the CDT codebook specifies that the evaluation, diagnosis and treatment planning components of the exam are the responsibility of the dentist, DMAP does not reimburse dental exams when furnished by a Dental Hygienist (with or without a limited access permit);

(B) For clients enrolled in a DCO, it is the responsibility of the Dental Hygienist to coordinate all dental services with the client's Dental Care Organization (DCO) prior to providing services;

(C) Regardless of whether a client is receiving services fee-for-service or through a DCO, if provided through a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC), refer to OAR 410 Division 147 for specific details.

(f) Space Management – Removable space maintainers will not be replaced if lost or damaged.

(9) Tobacco Cessation:

(a) Use CDT code D1320 on an American Dental Association (ADA) claim form when billing for tobacco cessation services;

(b) A maximum of 10 services is allowed within a three-month period;

(c) Follow criteria outlined in OAR 410-130-0190.

(10) Restorations -- Amalgam and Composite:

(a) Payment for restorations is limited to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) Current Dental Terminology (CDT) codebook for definitions of restorative procedures;

(b) All surfaces must be combined and billed one line per tooth using the appropriate code. For example, tooth #30 has a buccal amalgam and a MOD amalgam -- bill MOD, B, using code D2161;

(c) Payment for an amalgam or composite restoration and a crown on the same tooth will be denied;

(d) Payment is made for a surface once in each treatment episode regardless of the number or combination of restorations;

(e) Payment for occlusal adjustment and polishing of the restoration is included in the restoration fee;

(f) Posterior composite restorations will be paid at the same rate as amalgam restorations;

(g) Replacement of posterior composite restorations is limited to once every five years;

(10) Crowns:

(a) Acrylic Heat or Light Cured Crowns -- allowed for anterior permanent teeth only;

(b) Prefabricated Plastic Crowns -- allowed for anterior teeth only, permanent or primary;

(c) Permanent crowns -- allowed for anterior permanent teeth only. Clients must be 16 years or older. Radiographs required; history, diagnosis, and treatment plan may be requested;

(d) Payment for crowns for posterior teeth, permanent or primary is limited to stainless steel crowns;

(e) Payment for preparation of the gingival tissue is included in the fee for the crown;

(f) Payment for retention pins is limited to four per tooth;

(g) Crowns are covered only when there is significant loss of clinical crown and no other restoration will restore function. The following is not covered:

(A) Endodontic therapy alone (with or without a post) is not covered;

(B) Aesthetics (cosmetics);

(h) Crown replacement is limited to one every five years per tooth. Exceptions to this limitation may be made for crown damage due to acute trauma, based on the following factors:

(A) Extent of crown damage;

(B) Extent of damage to other teeth or crowns; and

(C) Extent of impaired mastication;

(i) Crowns are not covered in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason;

(j) Crowns will be covered if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures.

(11) Endodontics:

(a) Pulp Capping:

(i) Direct and indirect pulp caps are included in the restoration fee; no additional payment will be made for clients with the OHP Plus Benefit Package;

(ii) Direct pulp caps are covered as a separate service for clients with the OHP Standard benefit coverage package because restorations are not a covered benefit under this benefit package.

(b) Endodontic Therapy:

(A) Endodontics is covered only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;

(B) Retreatment is not covered for bicuspid or molars;

(C) Retreatment is limited to anterior teeth when:

(i) Crown-to-root ratio is 50:50 or better;

(ii) The tooth is restorable without other surgical procedures; or

(iii) If loss of tooth would result in the need for removable prosthodontics;

(D) Separate reimbursement for open-and-drain as a palliative procedure is allowed only when the root canal is not completed on the same date of service, or if the same practitioner or dental practitioner in the same group practice did not complete the procedure;

(E) The client's record must include appropriate documentation to support the services and level of care rendered;

(F) Root canal therapy is not covered for third molars;

(F) Endodontic Therapy is covered if the tooth is restorable within the OHP benefit coverage package.

(c) Endodontic Therapy on Permanent Teeth -- Apexification is limited to a maximum of five treatments on permanent teeth only.

(12) Periodontics:

(a) D4210 and D4211 – limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia;

(b) D4240, D4241, D4260 and D4261 -- allowed once every three years unless there is a documented medical/dental indication;

(c) D4341 and D4342 -- allowed once every two years. A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances. Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater;

(d) D4910 – limited to following periodontal therapy and allowed once every six months. For further consideration of more frequent periodontal maintenance benefits, office records must clearly reflect clinical indication, i.e., chart notes, pocket depths and radiographs;

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

(f) Surgical procedures include six months routine postoperative care;

(g) Note: DMAP will not reimburse for procedures identified by the following codes if performed on the same date of service:

(A) D1110 (Prophylaxis – adult);

(B) D1120 (Prophylaxis – child);

(C) D4210 (Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant);

(D) D4211 (Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant);

(E) D4260 (Osseous surgery, including flap entry and closure – four or more contiguous teeth or bounded teeth spaces per quadrant);

(F) D4261 (Osseous surgery, including flap entry and closure – one to three contiguous teeth or bounded teeth spaces per quadrant);

(G) D4341 (Periodontal scaling and root planning – four or more teeth per quadrant);

(H) D4342 (Periodontal scaling and root planning – one to three teeth per quadrant);

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

(J) D4910 (Periodontal maintenance).

(13) Removable Prosthodontics:

(a) Removable cast metal prosthodontics and full dentures are limited to clients 16 years or older;

(b) Adjustments to removable prosthodontics during the six-month period following delivery to clients are included in the fee;

(c) Replacement:

(A) Replacement of dentures and partials, when it cannot be made clinically serviceable by a less costly procedure (reline, rebase, repair, tooth replacement, etc.), is limited to once every five years and only if dentally appropriate. This does not imply that replacement of dentures or partials must be done once every five years, but only when dentally appropriate;

(B) The limitation of once every five years applies to the client regardless of whether the denture or partial was received while the client was on the Oregon Health Plan and regardless of Dental Care Organization (DCO) or Fee-for-Service (FFS) enrollment status. This includes clients that move from FFS to DCO, DCO to FFS, or DCO to DCO. For example: a client receives full dentures on February 1, 2007, while FFS and a year later enrolls in a DCO. The client would not be eligible for another full denture until February 2, 2012, regardless of DCO or FFS enrollment;

(C) Replacement of partial dentures with full dentures is payable five years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene will not warrant replacement;

(d) Relines:

(A) Reline of complete or partial dentures is allowed once every two years;

(B) Exceptions to this limitation may be made under the same conditions warranting replacement;

(C) Laboratory relines are not payable within five months after placement of an immediate denture;

(e) Tissue Conditioning:

(A) Tissue conditioning is allowed once per denture unit in conjunction with immediate dentures;

(B) One tissue conditioning is allowed prior to new prosthetic placement;

(f) Cast Partial Dentures:

(A) Cast partial dentures will not be approved if stainless steel crowns are used as abutments;

(B) Cast partial dentures must have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;

(C) Teeth to be replaced and teeth to be clasped are to be noted in the "remarks" section of the form;

(g) Denture Rebase Procedures:

(A) Rebase should only be done if a reline will not adequately solve the problem. Rebase is limited to once every three years;

(B) Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene will not warrant rebasing.

(h) Laboratory Denture Reline Procedures -- Limited to once every two years.

(14) Maxillofacial Prosthetics:

(a) For clients enrolled in managed care, maxillofacial prosthetics are to be billed using CPT or HCPCS coding on a CMS-1500 to the client's medical managed care organization (FCHP). Provision of maxillofacial prosthetics is included in the FCHP capitation and is not the DCO's responsibility;

(b) For fee-for-service clients, bill DMAP using CPT or HCPCS codes on a CMS-1500. Payment is based on the physician fee schedule;

(c) Table 123-1260-1 lists the maxillofacial prosthetics procedures as "medical."

(15) Oral Surgery:

(a) Oral surgical procedures that are directly related to the teeth and supporting structures that are not due to a medical condition must be billed on an ADA claim form, using CDT codes;

(b) Oral surgical services that are included in a dental plan benefit package which are performed in a dental office setting (including an oral surgeon's office):

(A) Do not require prior authorization (PA), and include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs and follow-up visits;

(B) Are billed on an American Dental Association (ADA) dental claim form, using CDT codes, except when the procedures are a result of a medical condition (i.e., fractures, cancer) which must be billed using a CMS-1500 claim form with the appropriate American Medical Association (AMA) CPT procedure/ICD-9 diagnosis codes;

(C) For clients enrolled in a Dental Care Organization (DCO), the DCO is responsible for payment of those services in the dental plan package;

(c) Oral surgical services performed in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting:

(A) Oral surgical services in a hospital setting and related anesthesia services require PA;

(B) If the hospital setting oral surgical procedures are directly related to the teeth and supporting structures, the procedures must be billed on an ADA claim form, using CDT codes;

(C) If the services requiring hospital dentistry are the result of a medical condition/diagnosis (i.e., fracture, cancer), use appropriate AMA CPT procedure codes/ICD-9 diagnosis codes and bill procedures on a CMS-1500 claim form;

(D) For clients enrolled in a Fully Capitated Health Plan (FCHP), the facility charge and anesthesia services are the responsibility of the FCHP. For clients enrolled in a Physician Care Organization (PCO), the outpatient facility charge (including ambulatory surgical centers) and anesthesia are the responsibility of the PCO. Refer to the current Medical Surgical Services administrative rules in OAR Chapter 410 – Division 130 for more information;

(d) All codes listed as “By Report” require an operative report;

(e) Payment for tooth reimplantation is covered only in cases of traumatic avulsion where there are good indications of success;

(f) Biopsies collected are reimbursed by the dental plan. Reimbursement for laboratory services of biopsies must be arranged through the medical plan;

(g) Surgical excisions of soft tissue lesions (D7410 – D7415) are not covered services;

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

(i) Surgical Extractions:

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

(B) Surgical removal of impacted teeth or removal of residual tooth roots are limited to treatment for only those teeth that have acute infection or abscess, , severe tooth pain, and/or unusual swelling of the face or gums.

(C) Alveoloplasty in conjunction with extractions (D7310 and D7311) are not services that are covered separately from the extraction. Alveoloplasty not in conjunction with extractions (D7320) is a covered service.

(j) Table 123-1260-1 in this rule lists CDT procedure codes on the Health Services Commission's (HSC) Prioritized List of Health Services (List) that also have CPT medical codes. The procedures listed as "medical" on the table may be covered as medical procedures, the table may not be all-inclusive of every dental code that has a corresponding medical code;

(A) If billed as a medical procedure in accordance with these rules, the procedure must be billed on a CMS-1500, using CPT coding. Refer to the Medical-Surgical administrative rules for additional information (OAR Chapter 410 – Division 130);

(B) If a client is enrolled in a Fully Capitated Health Plan (FCHP) or a Physician Care Organization (PCO), it is the responsibility of the provider to contact the FCHP or the PCO for any required authorization before the service is rendered.

(16) Orthodontia:

(a) Orthodontia services and extractions are limited to eligible clients:

(A) With the ICD-9-CM diagnosis of cleft palate with cleft lip; and

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

(C) When surgical corrections of cleft palate with cleft lip was not completed prior to age 21;

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

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

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

(e) Orthodontia treatment for cleft palate/cleft lip is evaluated as two phases. Stage one is generally the use of an activator (palatal expander) and stage two is generally the placement of fixed appliances (banding). Each phase is reimbursed individually (separately);

(f) Payment for orthodontia will be made in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist must refund to DMAP any unused amount of payment, after applying the following formula: Total payment minus \$300.00 (for Banding) multiplied by the percentage of treatment remaining;

(g) The length of the treatment plan from the original request for authorization will be used to determine the number of treatment months remaining;

(h) As long as the orthodontist continues treatment no refund will be required even though the client may become ineligible for medical assistance sometime during the treatment period;

(i) Code:

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

(B) Codes D8010-D8999 -- PA required.

(17) Anesthesia:

(a) General anesthesia or IV sedation is to be used only for those clients with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure (D9220, D9221, D9241 and D9242);

(b) General anesthesia or IV sedation is paid using codes D9220 or D9241, respectively, for the first 30 minutes and using codes D9221 or D9242, respectively, for each additional 15-minute period, up to three hours on the

same day of service. When using codes D9221 or D9242, use care when entering quantity. Each 15-minute period represents a quantity of one. Enter this number in the quantity column;

(c) Nitrous oxide is paid per date of service, not by time;

(d) Oral pre-medication anesthesia for conscious sedation:

(A) Limited to clients through 12 years of age;

(B) Limited to four times per year;

(C) Monitoring and nitrous oxide included in the fee; and

(D) Use of multiple agents is required to receive payment;

(e) Upon request, providers must submit to DMAP a copy of their permit to administer anesthesia, analgesia and/or sedation;

(f) Anesthesia -- For the purpose of Title XIX and Title XXI, code D9630 is limited to those oral medications used during a procedure and is not intended for "take home" medication.

(18) Office visit for observation – Code D9430 is limited to three visits per year.

Table 123-1260-1

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08

## **Table 123-1260-1 – Covered Dental Services**

- Codes listed in this table are covered services for the specific benefit package listed.
- If dental services are billed as medical pursuant to rule, they are billed on a CMS-1500 using CPT or HCPCS codes and ICD-9-CM diagnosis codes. (The procedures listed as “medical” on the table below may be covered as medical procedures, however, the table may not be all-inclusive of every dental code that has a corresponding medical code.).
- Fees can be found on DHS’ Fee-For-Service Fee Schedule. Those listed as Pricing Action Code (PAC) 5 are manually priced and will be paid at a percentage of the billed charge until sufficient data is available to price the code.
- BR = By Report. Clinical documentation required prior to payment determination.

**Table 123-1260-1 Covered Dental Services**

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D0120	periodic oral eval-established patient	Yes	No		
D0140	limited oral eval-problem focus	Yes	Yes		
D0145	oral evaluation, pt < 3yrs	Yes	No		
D0150	comprehensive oral eval-new or established	Yes	No		
D0160	extensive oral eval-problem focus	Yes	No		
D0170	re-eval limited, problem focus	Yes	Yes		
D0180	comp periodic eval-new or established	Yes	No		
D0210	intraoral-complete series	Yes	No		
D0220	intraoral-periapical first film	Yes	Yes		
D0230	introral-periapical each addtl	Yes	Yes		
D0240	intraoral-occlusal	Yes	Yes		
D0250	extraoral-first	Yes	Yes		
D0260	extraoral-each addtl	Yes	Yes		
D0270	bitewing-single	Yes	Yes		
D0272	bitewing-two films	Yes	Yes		
D0273	bitewing-three films	Yes	Yes		
D0274	bitewing-four films	Yes	No		
D0277	vertical bitewing 7-8	Yes	No		
D0290	posterior-anterior or skull & facial film	Yes	No		
D0310	sialography	Yes	No	BR	
D0320	TMJ arthrogram	Yes	No	BR	
D0321	other TMJ films	Yes	No		
D0322	tomographic survey	Yes	No	BR	
D0330	panoramic film	Yes	Yes		
D0340	cephalometric film	Yes	No		
D0350	oral/facial photographic image	Yes	No		
D0360	cone beam ct	Yes	Yes	BR	
D0362	cone beam, two dimensional	Yes	Yes	BR	
D0363	cone beam, three dimensional	Yes	Yes	BR	
D0415	collection for culture and sensitivity	Yes	No	BR	
D0416	viral culture	No	No		
D0421	genetic test oral disease	No	No		
D0425	caries susceptibility test	No	No		
D0431	adjunctive pre-diagnostic test	No	No		
D0460	pulp vitality	No	No		
D0470	diagnostic casts	No	No		
D0472	accession of tissue	Yes	No		
D0473	accession of tissue	Yes	No		
D0474	accession of tissue	Yes	No		
D0475	decalcification proc	No	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D0476	special stains for microorganism	No	No		
D0477	special stains not for microorganism	No	No		
D0478	immunohistochemical stains	No	No		
D0479	tissue in-situ hybridization	No	No		
D0480	accession of exfoliative cytologic smears	Yes	No		
D0481	electron microscopy	No	No		
D0482	direct immunofluorescence	No	No		
D0483	indirect immunofluorescence	No	No		
D0484	consult on slides prepared elsewhere	No	No		
D0485	consultation	No	No		
D0486	accession of brush biopsy	Yes	No	BR	
D0502	other oral path proc	Yes	No	BR	
D0999	unspecified diagnostic proc	No	No		
D1110	prophylaxis-adult	Yes	No		
D1120	prophylaxis-child	Yes	No		
D1201	fluoride-child (Deleted for 2007)	Yes	No		
D1203	topical fluoride-child	Yes	No		
D1204	topical fluoride-adult	Yes	No		
D1204	fluoride-adult (Deleted for 2007)	No	No		
D1206	topical fluoride varnish, mod to high risk	Yes	No		
D1310	nutritional counseling	No	No		
D1320	tobacco counseling	Yes	No		
D1330	oral hygiene instructions	No	No		
D1351	sealant	Yes	No		
D1510	space maintainer-fixed unilateral	Yes	No		
D1515	space maintainer-fixed bilateral	Yes	No		
D1520	space maintainer-removable unilateral	Yes	No		
D1525	space maintainer-removable bilateral	Yes	No		
D1550	re-cementation space maintainer	Yes	No		
D1555	removal fixed space maintainer	Yes	No		
D2140	amalgam-1 surface prim or perm	Yes	No		
D2150	amalgam-2 surface prim or perm	Yes	No		
D2160	amalgam-3 surface prim or perm	Yes	No		
D2161	amalgam-4 or more surface prim or perm	Yes	No		
D2330	resin based composite- 1 anterior	Yes	No		
D2331	resin based composite- 2 anterior	Yes	No		
D2332	resin based composite- 3 anterior	Yes	No		
D2335	resin based composite- 4 or > anterior	Yes	No		
D2390	resin based composite-crown anterior	Yes	No		
D2391	resin based composite- 1 posterior	Yes	No		
D2392	resin based composite- 2 posterior	Yes	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D2393	resin based composite- 3 posterior	Yes	No		
D2394	resin based composite- 4 or > posterior	Yes	No		
D2410	gold foil- 1 surface	No	No		
D2420	gold foil- 2 surface	No	No		
D2430	gold foil- 3 surface	No	No		
D2510	inlay metallic- 1 surface	No	No		
D2520	inlay metallic- 2 surface	No	No		
D2530	inlay metallic- 3 or more surface	No	No		
D2542	onlay metallic- 2 surface	No	No		
D2543	onlay metallic- 3 surface	No	No		
D2544	onlay metallic- 4 or more surface	No	No		
D2610	inlay porcelain/ceramic- 1 surface	No	No		
D2620	inlay porcelain/ceramic- 2 surface	No	No		
D2630	inlay porcelain/ceramic- 3 or more surface	No	No		
D2642	onlay porcelain/ceramic- 2 surface	No	No		
D2643	onlay porcelain/ceramic-3 surface	No	No		
D2644	onlay porcelain/ceramic- 4 or more surface	No	No		
D2650	inlay resin-based composite- 1 surface	No	No		
D2651	inlay resin-based composite- 2 surface	No	No		
D2652	inlay resin-based composite- 3 or > surface	No	No		
D2662	onlay resin-based composite- 2 surface	No	No		
D2663	onlay resin-based composite- 3 surface	No	No		
D2664	onlay resin-based composite- 4 or > surface	No	No		
D2710	crown resin based composite	Yes	No		
D2712	crown 3/4 resin based composite	No	No		
D2720	crown resin with high noble metal	No	No		
D2721	crown resin with predominantly base metal	Yes	No		
D2722	crown resin with noble metal	Yes	No		
D2740	crown porcelain/ceramic	No	No		
D2750	crown porcelain fused to high noble metal	No	No		
D2751	crown porcelain fused to predom base metal	Yes	No		
D2752	crown porcelain fused to noble metal	Yes	No		
D2780	crown 3/4 cast high noble metal	No	No		
D2781	crown 3/4 cast predominantly base metal	No	No		
D2782	crown 3/4 cast noble metal	No	No		
D2783	crown 3/4 porcelain/ceramic	No	No		
D2790	crown full cast high noble metal	No	No		
D2791	crown full cast predominantly base metal	No	No		
D2792	crown full cast noble metal	No	No		
D2794	crown titanium	No	No		
D2799	provisional crown	No	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D2910	recement inlay, onlay or part coverage restoration	Yes	Yes		
D2915	recement cast or prefabricated post and core	No	No		
D2920	recement crown	Yes	Yes		
D2930	crown prefabricated stainless steel prim	Yes	No		
D2931	crown prefabricated stainless steel perm	Yes	No		
D2932	crown prefabricated resin	Yes	No		
D2933	crown prefab stainless steel w resin window	Yes	No		
D2934	crown prefab esthetic coated stainless steel prim	No	No		
D2940	sedative filling	Yes	Yes		
D2950	core buildup	Yes	No		
D2951	pin retention	Yes	No		
D2952	post & core in addt to crown, indirectly fabricated	No	No		
D2953	post-each addtl indirectly fabricated	No	No		
D2954	prefabricated post & core	Yes	No		
D2955	post removal	Yes	No		
D2957	prefabricated post -each addtl	Yes	No		
D2960	labial veneer, resin laminate - chairside	No	No		
D2961	labial veneer, resin laminate - laboratory	No	No		
D2962	labial veneer, porcelain laminate - laboratory	No	No		
D2970	crown temporary fractured tooth	Yes	No		
D2971	construct new crown under existing partial	No	No		
D2980	crown repair	Yes	No	BR	
D2999	unspecified restorative proc	No	No		
D3110	pulp cap direct	No	Yes		
D3120	pulp cap indirect	No	No		
D3220	therapeutic pulpotomy	Yes	Yes		
D3221	pulpal debridement	Yes	Yes		
D3230	pulpal therapy - anterior, primary	Yes	No		
D3240	pulpal therapy - posterior, primary	Yes	No		
D3310	anterior	Yes	No		
D3320	bicuspid	Yes	No		
D3330	molar	Yes	No		
D3331	root canal obstruction, non surgical	Yes	No		
D3332	incomplete endodontic therapy	Yes	No	BR	
D3333	internal root repair of perforation defects	Yes	No	BR	
D3346	previous root canal therapy-anterior	Yes	No	BR	
D3347	previous root canal therapy-bicuspid	No	No		
D3348	previous root canal therapy-molar	No	No		
D3351	apexification/recalcification-initial visit	Yes	No		
D3352	apexification/recalcification-interim med replacement	Yes	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D3353	apexification/recalcification-final visit	Yes	No	BR	
D3410	apicoectomy/periradicular surgery-anterior	Yes	No		
D3421	apicoectomy/periradicular surgery-bicuspid	No	No		
D3425	apicoectomy/periradicular surgery-molar	No	No		
D3426	apicoectomy/periradicular surgery-each addtl root	No	No		
D3430	retrograde filling	No	No		
D3450	root amputation	No	No		
D3460	endodontic endosseous implant	No	No		
D3470	reimplantation	No	No		
D3910	surgical proc for isolation of tooth w rubber dam	No	No		
D3920	hemisection	No	No		
D3950	canal prep	Yes	No		
D3999	unspecified endodontic proc	No	No		
D4210	gingivectomy/gingivoplasty- 4 or more teeth	Yes	No		
D4211	gingivectomy/gingivoplasty- 1 to 3 teeth	Yes	No		
D4230	anatomical crown exposure- 4 or > teeth	No	No		
D4231	anatomical crown exposure- 1 to 3 teeth	No	No		
D4240	gingival flap proc- 4 or more teeth	Yes	No		
D4241	gingival flap proc- 1 to 3 teeth	Yes	No		
D4245	apically positioned flap	Yes	No		
D4249	clinical crown lengthening	No	No		
D4260	osseous surgery- 4 or more teeth	Yes	No		
D4261	osseous surgery- 1 to 3 teeth	Yes	No		
D4263	bone replacement graft- first site	No	No		
D4264	bone replacement graft- each addtl site	No	No		
D4265	biologic materials	No	No		
D4266	tissue regeneration, resorbable barrier	No	No		
D4267	tissue regeneration, nonresorbable barrier	No	No		
D4268	surgical revision	Yes	No		
D4270	pedicle soft tissue graft	No	No		
D4271	free soft tissue graft	No	No		
D4273	subepithelial connective tissue graft	No	No		
D4274	distal or proximal wedge	No	No		
D4275	soft tissue allograft	No	No		
D4276	combined connective tissue & pedicle graft	No	No		
D4320	provisional splinting- intracoronal	No	No		
D4321	provisional splinting- extracoronal	No	No		
D4341	periodontal scaling- 4 or more teeth	Yes	No		
D4342	periodontal scaling- 1 to 3 teeth	Yes	No		
D4355	full mouth debridement	Yes	No		
D4381	localized delivery of antimicrobial agents	No	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D4910	periodontal maintenance	Yes	No		
D4920	unscheduled dressing change	Yes	No	BR	
D4999	unspecified periodontal proc	No	No		
D5110	complete denture-maxillary	Yes	No		
D5120	complete denture-mandibular	Yes	No		
D5130	immediate denture-maxillary	Yes	No		
D5140	immediate denture-mandibular	Yes	No		
D5211	partial denture-maxillary-resin	No	No		
D5212	partial denture-mandibular-resin	No	No		
D5213	partial denture-maxillary-cast metal	Yes	No		
D5214	partial denture-mandibular-cast metal	Yes	No		
D5225	partial denture-maxillary-flexible base	No	No		
D5226	partial denture-mandibular-flexible base	No	No		
D5281	partial denture-removable unilateral	No	No		
D5410	adjust complete denture-maxillary	Yes	No		
D5411	adjust complete denture-mandibular	Yes	No		
D5421	adjust partial denture-maxillary	Yes	No		
D5422	adjust partial denture-mandibular	Yes	No		
D5510	repair broken complete denture base	Yes	No		
D5520	replace missing/broken teeth-complete denture	Yes	No		
D5610	repair resin denture	Yes	No		
D5620	repair cast framework	Yes	No		
D5630	repair/replace broken clasp	Yes	No		
D5640	replace broken tooth	Yes	No		
D5650	add tooth to existing partial denture	Yes	No		
D5660	add clasp to existing partial denture	Yes	No		
D5670	replace all teeth-maxillary	No	No		
D5671	replace all teeth-mandibular	No	No		
D5710	rebase complete denture-maxillary	Yes	No		
D5711	rebase complete denture-mandibular	Yes	No		
D5720	rebase partial denture-maxillary	Yes	No		
D5721	rebase partial denture-mandibular	Yes	No		
D5730	reline complete denture-maxillary	Yes	No		
D5731	reline complete denture-mandibular	Yes	No		
D5740	reline partial denture-maxillary	Yes	No		
D5741	reline partial denture-mandibular	Yes	No		
D5750	reline complete denture-maxillary-lab	Yes	No		
D5751	reline complete denture-mandibular-lab	Yes	No		
D5760	reline partial denture-maxillary-lab	Yes	No		
D5761	reline partial denture-mandibular-lab	Yes	No		
D5810	interim complete denture-maxillary	No	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D5811	interim complete denture-mandibular	No	No		
D5820	interim partial denture-maxillary	Yes	No		
D5821	interim partial denture-mandibular	Yes	No		
D5850	tissue conditioning-maxillary	Yes	No		
D5851	tissue conditioning-mandibular	Yes	No		
D5860	overdenture-complete	No	No		
D5861	overdenture-partial	No	No		
D5862	precision attachment	No	No		
D5867	replace semi-precision or precision attachment	No	No		
D5875	modification of removable prosthesis	No	No		
D5899	unspecified removable prosthodontic proc	No	No		
D5911	facial moulage-sectional	Yes	No		Medical
D5912	facial moulage-complete	Yes	No		Medical
D5913	nasal prosthesis	Yes	No		Medical
D5914	auricular prosthesis	No	No		Medical
D5915	orbital prosthesis	Yes	No		Medical
D5916	ocular prosthesis	Yes	No		Medical
D5919	facial prosthesis	Yes	No		Medical
D5922	nasal septal prosthesis	Yes	No		Medical
D5923	ocular prosthesis-interim	Yes	No		Medical
D5924	cranial prosthesis	Yes	No		Medical
D5925	facial augmentation	Yes	No		Medical
D5926	nasal prosthesis-replacement	Yes	No		Medical
D5927	auricular prosthesis-replacement	No	No		
D5928	orbital prosthesis-replacement	Yes	No		Medical
D5929	facial prosthesis-replacement	Yes	No		Medical
D5931	obturator prosthesis-surgical	Yes	No		Medical
D5932	obturator prosthesis-definitive	Yes	No		Medical
D5933	obturator prosthesis-modification	Yes	No		Medical
D5934	mandibular resection prosthesis w guide flange	Yes	No		Medical
D5935	mandibular resection prosthesis w/o guide flange	Yes	No		Medical
D5936	obturator prosthesis-interim	Yes	No		Medical
D5937	trismus appliance	Yes	No		Medical
D5951	feeding aid	Yes	No		Medical
D5952	speech aid prosthesis-pediatric	Yes	No		Medical
D5953	speech aid prosthesis-adult	Yes	No		Medical
D5954	palatal augmentation prosthesis	Yes	No		Medical
D5955	palatal lift prosthesis-definitive	Yes	No		Medical
D5958	palatal lift prosthesis-interim	Yes	No		Medical
D5959	palatal lift prosthesis-modification	Yes	No		Medical
D5960	speech aid prosthesis-modification	Yes	No		Medical

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D5982	surgical stent	No	No		
D5983	radiation carrier	Yes	No		Medical
D5984	radiation shield	Yes	No		Medical
D5985	radiation cone locator	Yes	No		Medical
D5986	fluoride gel carrier	Yes	No		Medical
D5987	comissure splint	Yes	No		Medical
D5988	surgical splint	No	No		
D5999	unspecified maxillofacial prosthesis	No	No		
D6010	surgical placement of implant body-endosteal	No	No		
D6012	surgical placement of interim implant body for transitional prosthesis-endosteal	No	No		
D6040	surgical placement-eposteal implant	No	No		
D6050	surgical placement-transosteal implant	No	No		
D6053	implant/abutment supported removable denture-completely edentulous arch	No	No		
D6054	implant/abutment supported removable denture-partially edentulous arch	No	No		
D6055	dental implant supported connecting bar	No	No		
D6056	prefabricated abutment	No	No		
D6057	custom abutment	No	No		
D6058	abutment supported porcelain/ceramic crown	No	No		
D6059	abutment supported porcelain fused to metal crown-high noble metal	No	No		
D6060	abutment supported porcelain fused to metal crown-predominantly base metal	No	No		
D6061	abutment supported porcelain fused to metal crown-noble metal	No	No		
D6062	abutment supported cast metal crown-high noble metal	No	No		
D6063	abutment supported cast metal crown-predominantly base metal	No	No		
D6064	abutment supported cast metal crown-noble metal	No	No		
D6065	implant supported porcelain/ceramic crown	No	No		
D6066	implant supported porcelain fused to metal crown	No	No		
D6067	implant supported metal crown	No	No		
D6068	abutment supported retainer-porcelain/ceramic FPD	No	No		
D6069	abutment supported retainer-porcelain fused to metal FPD, high noble metal	No	No		
D6070	abutment supported retainer-porcelain fused to metal FPD, predom base metal	No	No		
D6071	abutment supported retainer-porcelain fused to metal FPD, noble metal	No	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D6072	abutment supported retainer-cast metal FPD, high noble metal	No	No		
D6073	abutment supported retainer-cast metal FPD, predom base metal	No	No		
D6074	abutment supported retainer-cast metal FPD, noble metal	No	No		
D6075	Implant supported retainer-ceramic FPD	No	No		
D6076	metal FPD	No	No		
D6077	Implant supported retainer-cast metal FPD	No	No		
D6078	Implant/abutment supported fixed denture-completely edentulous arch	No	No		
D6079	Implant/abutment supported fixed denture-partially edentulous arch	No	No		
D6080	implant maintenance	No	No		
D6090	repair implant abutment	No	No		
D6091	replace semi/precision attachment	No	No		
D6092	recement implant/abutment supported crown	No	No		
D6093	recement implant/abutment supported fixed partial	No	No		
D6094	abutment supported crown	No	No		
D6095	repair implant abutment	No	No		
D6100	Implant removal	No	No		
D6190	radiographic/surgical implant index	No	No		
D6194	abutment supported retainer crown for FPD	No	No		
D6199	unspecified implant proc	No	No		
D6205	pontic-indirect resin based	No	No		
D6210	pontic-cast high noble metal	No	No		
D6211	pontic-cast predom base metal	No	No		
D6212	pontic-cast noble metal	No	No		
D6214	pontic-titanium	No	No		
D6240	pontic-porcelain fused to high noble metal	No	No		
D6241	pontic-porcelain fused to predom base metal	No	No		
D6242	pontic-porcelain fused to noble metal	No	No		
D6245	pontic-porcelain/ceramic	No	No		
D6250	pontic-resin w/ high noble metal	No	No		
D6251	pontic-resin w/ predom base metal	No	No		
D6252	pontic-resin w/ noble metal	No	No		
D6253	provisional pontic	No	No		
D6545	retainer-cast metal, resin bonded fixed pros	No	No		
D6548	pros	No	No		
D6600	inlay-porcelain/ceramic 2 surface	No	No		
D6601	inlay-porcelain/ceramic 3 or > surface	No	No		
D6602	inlay-cast high noble 2 surface	No	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D6603	inlay-cast high noble 3 or > surface	No	No		
D6604	inlay-cast predom base 2 surface	No	No		
D6605	inlay-cast predom base 3 or > surface	No	No		
D6606	inlay-cast noble 2 surface	No	No		
D6607	inlay-cast noble 3 or > surface	No	No		
D6608	onlay-porcelain/ceramic 2 surface	No	No		
D6609	onlay-porcelain/ceramic 3 or > surface	No	No		
D6610	onlay-cast high noble 2 surface	No	No		
D6611	onlay-cast high noble 3 or > surface	No	No		
D6612	onlay-cast predom base 2 surface	No	No		
D6613	onlay-cast predom base 3 or > surface	No	No		
D6614	onlay-cast noble 2 surface	No	No		
D6615	onlay-cast noble 3 or > surface	No	No		
D6624	inlay-titanium	No	No		
D6634	onlay-titanium	No	No		
D6710	crown-indirect resin based	No	No		
D6720	crown-resin w/ high noble metal	No	No		
D6721	crown-resin w/ predom base metal	No	No		
D6722	crown-resin w/ noble metal	No	No		
D6740	crown-porcelain/ceramic	No	No		
D6750	crown--porcelain fused to high noble metal	No	No		
D6751	crown--porcelain fused to predom base metal	No	No		
D6752	crown-porcelain fused to noble metal	No	No		
D6780	crown-3/4 cast high noble metal	No	No		
D6781	crown-3/4 cast predom base metal	No	No		
D6782	crown-3/4 cast noble metal	No	No		
D6783	crown-3/4 porcelain/ceramic	No	No		
D6790	crown-full cast high noble metal	No	No		
D6791	crown-full cast predom base metal	No	No		
D6792	crown-full cast noble metal	No	No		
D6793	provisional retainer crown	No	No		
D6794	crown-titanium	No	No		
D6920	connector bar	No	No		
D6930	recrement fixed partial denture	Yes	Yes		
D6940	stress breaker	No	No		
D6950	precision attachment	No	No		
D6970	post & core, indirectly fabricated	No	No		
D6971	prosthodontics (Deleted for 2007)	No	No		
D6972	prefabricated post & core	No	No		
D6973	core build up	No	No		
D6975	coping - metal	No	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D6976	indirectly fabricated post-each addtl	No	No		
D6977	prefabricated post-each addtl	No	No		
D6980	fixed partial denture repair	Yes	No	BR	
D6985	pediatric partial denture, fixed	No	No		
D6999	unspecified fixed prosthodontics proc	No	No		
D7111	extraction-coronal remnants, deciduous tooth	Yes	Yes		
D7140	extraction-erupted tooth or exposed root	Yes	Yes		
D7210	surgical removal-erupted tooth	Yes	Yes		
D7220	removal impacted tooth-soft tissue	Yes	Yes		
D7230	removal impacted tooth-partially bony	Yes	Yes		
D7240	removal impacted tooth-completely bony	Yes	Yes		
D7241	remove impacted tooth-completely bony w/ complications	Yes	Yes	BR	
D7250	surgical removal of residual roots	Yes	Yes		
D7260	oroantral fistula closure	Yes	Yes		
D7261	primary closure of sinus perforation	No	No		
D7270	tooth reimplantation	Yes	Yes		
D7272	tooth transplantation	No	No		
D7280	surgical access unerupted tooth	No	No		
D7282	mobilization erupted/malpositioned tooth	No	No		
D7283	tooth	No	No		
D7285	biopsy of oral tissue-hard	Yes	No	BR	Medical
D7286	biopsy of oral tissue-soft	Yes	No		Medical
D7287	exfoliative cytological sample collection	Yes	No	BR	Medical
D7288	brush biopsy	Yes	No	BR	Medical
D7290	surgical repositioning of teeth	No	No		
D7291	transseptal fiberotomy/supra crestal fiberotomy	No	No		
D7292	screw retained plate	No	No		
D7293	temp anchorage device w flap	No	No		
D7294	temp anchorage device w/o flap	No	No		
D7310	alveoloplasty in conjunction with extraction-4 or > teeth	No	No		
D7311	alveoloplasty in conjunction with extraction-1 to 3 teeth	No	No		
D7320	alveoloplasty not in conjunction w extraction-4 or > teeth	Yes	No		
D7321	alveoloplasty not in conjunction w extraction-1 to 3 teeth	No	No		
D7340	vestibuloplasty ridge extension	Yes	No	BR	Medical
D7350	vestibuloplasty ridge extension w/ graft	Yes	No	BR	Medical
D7410	excision of benign lesion-<=1.25 cm	No	No		
D7411	excision of benign lesion->1.25 cm	No	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D7412	excision of benign lesion, complicated	No	No		
D7413	excision of malignant lesion-<=1.25 cm	No	No		
D7414	excision of malignant lesion->1.25 cm	No	No		
D7415	excision of malignant lesion, complicated	No	No		
D7440	excision malig tumor-<=1.25 cm	Yes	No	BR	Medical
D7441	excision malig tumor->1.25 cm	Yes	No	BR	Medical
D7450	remove benign odontogenic cyst-<=1.25cm	Yes	No		Medical
D7451	remove benign odontogenic cyst->1.25cm	Yes	No		Medical
D7460	remove benign nonodontogenic cyst-<=1.25cm	No	No		
D7461	remove benign nonodontogen cyst->1.25cm	No	No		
D7465	Destruction of lesion - physical or chemical method	Yes	No		Medical
D7471	remove lateral exostosis	Yes	No		Medical
D7472	remove torus palatinus	No	No		
D7473	remove torus madibularis	No	No		
D7485	surgical reduction osseous tuberosity	No	No		
D7490	radical resection maxilla or mandible	Yes	No	BR	Medical
D7510	incision/drain abscess intra	Yes	Yes		
D7511	incision/drain abscess intra, complicated	Yes	No	BR	Medical
D7520	incision/drain abscess extra	Yes	Yes		
D7521	incision/drain abscess extra, complicated	Yes	No	BR	
D7530	remove foreign body skin/alveolar tissue	Yes	No		Medical
D7540	remove reaction producing foreign body	Yes	No	BR	
D7550	partial ostectomy/sequestrectomy non vital bone	Yes	No	BR	
D7560	maxillary sinusotomy	Yes	No	BR	Medical
D7610	simple fracture-maxilla open reduction	Yes	No	BR	
D7620	simple fracture-maxilla closed reduction	Yes	No	BR	
D7630	simple fracture-mandible open reduction	Yes	No	BR	
D7640	simple fracture-mandible closed reduction	Yes	No	BR	
D7650	simple fracture-malar/zygomatic open reduction	Yes	No	BR	
D7660	simple fracture-malar/zygomatic closed reduction	Yes	No	BR	
D7670	simple fracture-alveolus closed reduction	Yes	No		
D7671	simple fracture-alveolus open reduction	No	No		
D7680	simple fracture-facial bones-complicated reduction	Yes	No	BR	
D7710	compound fracture-maxilla open reduction	Yes	No	BR	
D7720	compound fracture-maxilla closed reduction	Yes	No		
D7730	compound fracture-mandible open reduction	Yes	No	BR	
D7740	compound fracture-mandible closed reduction	Yes	No	BR	
D7750	compound fracture-malar/zygomatic open reduction	Yes	No	BR	
D7760	compound fracture-malar/zygomatic closed reduction	Yes	No	BR	

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D7770	compound fracture-alveolus closed reduction	Yes	No	BR	
D7771	compound fracture-alveolus open reduction	No	No		
D7780	compound fracture-facial bones-complicated reduction	Yes	No	BR	
D7810	TMJ open reduction of dislocation	No	No		Medical
D7820	TMJ closed reduction of dislocation	No	No		Medical
D7830	TMJ manipulation under anesthesia	No	No		Medical
D7840	condylectomy	No	No		
D7850	surgical discectomy	No	No		
D7852	disc repair	No	No		
D7854	synovectomy	No	No		
D7856	myotomy	No	No		
D7858	joint reconstruction	No	No		
D7860	arthrotomy	No	No		
D7865	arthroplasty	No	No		
D7870	arthrocentesis	No	No		
D7871	non-artroscopic lysis and lavage	No	No		
D7872	arthroscopy-diagnosis	No	No		
D7873	arthroscopy-surgical, lavage & lysis of adhesions	No	No		
D7874	arthroscopy-surgical, disc reposition	No	No		
D7875	arthroscopy-surgical, synovectomy	No	No		
D7876	arthroscopy-surgical,discectomy	No	No		
D7877	arthroscopy-surgical, debridement	No	No		
D7880	occlusal orthotic device	No	No		
D7899	unspecified TMD therapy	No	No		
D7910	suture small wound <=5cm	Yes	No		
D7911	suture complicated <= 5cm	Yes	Yes		
D7912	suture complicated > 5 cm	Yes	No		Medical
D7920	skin graft	Yes	No	BR	Medical
D7940	osteoplasty-orthognathic deformities	No	No		
D7941	osteotomy-mandibular rami	No	No		
D7943	osteotomy-mandibular rami w/bone graft	No	No		
D7944	osteotomy-segmented or subapical	No	No		
D7945	osteotomy-body of mandible	No	No		
D7946	lefort I-maxilla total	No	No		
D7947	lefort I-maxilla segmented	No	No		
D7948	lefort II or III w/o bone graft	No	No		
D7949	lefort II or III w/bone graft	No	No		
D7950	osseous, osteoperiosteal, or cartilage graft-autogenous or non-autogenous	Yes	No	BR	Medical
D7951	sinus augmentation w bone/bone substitutes	No	No		
D7953	bone replacement graft	No	No		

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D7955	repair maxillofacial tissue defect	No	No		
D7960	frenulectomy	No	No		
D7963	frenuloplasty	No	No		
D7970	excision hyperplastic tissue	Yes	No		
D7971	excision pericoronar gingiva	No	No		
D7972	surgical reduction fibrous tuberosity	No	No		
D7980	sialolithotomy	Yes	No	BR	Medical
D7981	excision of salivary gland	Yes	No	BR	Medical
D7982	sialodochoplasty	Yes	No	BR	Medical
D7983	closure of salivary fistula	Yes	No	BR	Medical
D7990	emergency tracheotomy	Yes	No	BR	
D7991	coronoidectomy	No	No		
D7995	synthetic graft	No	No		
D7996	implant-mandible for augmentation	No	No		
D7997	appliance removal	Yes	No	BR	
D7998	intraoral placement of fixation device	No	No		
D7999	unspecified oral surgery proc	No	No		
D8010	limited orthodontic primary dentition	Yes	No	BR	
D8020	limited orthodontic transitional dentition	Yes	No	BR	
D8030	limited orthodontic adolescent dentition	Yes	No	BR	
D8040	limited orthodontic adult dentition	Yes	No	BR	
D8050	interceptive orthodontic primary dentition	Yes	No	BR	
D8060	interceptive orthodontic transitional dentition	Yes	No	BR	
D8070	comprehensive orthodontic transitional dentition	Yes	No	BR	
D8080	comprehensive orthodontic adolescent dentition	Yes	No	BR	
D8090	comprehensive orthodontic adult dentition	Yes	No	BR	
D8210	removable appliance therapy	Yes	No	BR	
D8220	fixed appliance therapy	Yes	No	BR	
D8660	pre-orthodontic visit	Yes	No	BR	
D8670	periodic orthodontic visit	Yes	No	BR	
D8680	orthodontic retention	Yes	No	BR	
D8690	orthodontic treatment-alternative billing	Yes	No	BR	
D8691	repair orthodontic appliance	No	No		
D8692	replacement lost/broken retainer	No	No		
D8693	rebond/cement/repair retainer	No	No		
D8999	unspecified orthodontics proc	Yes	No	BR	
D9110	palliative treatment dental pain	Yes	Yes		
D9120	fix partial denture sectioning	No	No		
D9210	local anesthesia	No	Yes		
D9211	regional block anesthesia	Yes	No	BR	Medical
D9212	trigeminal block anesthesia	Yes	No		Medical

DENTAL CODES	DESCRIPTION	OHP PLUS BENEFIT PACKAGE	OHP STANDARD BENEFIT PACKAGE	BR = BY REPORT	MEDICAL = ALSO HAS CPT MEDICAL CODE
D9215	local anesthesia	No	Yes		
D9220	deep sedation/general anesth-1st 30min	Yes	No		
D9221	deep sedation/gen anesth-ea addtl 15min	Yes	No		
D9230	analgesia, anxiolysis, nitrous oxide	Yes	Yes		
D9241	IV conscious sedation-1st 30min	Yes	No		
D9242	IV conscious sedation-ea addtl 15min	Yes	No		
D9248	non-IV conscious sedation	Yes	No		
D9310	consultation	Yes	No		
D9410	house/LTC facility call	No	No		
D9420	hospital call	Yes	Yes		
D9430	office visit for observation	Yes	No		
D9440	office after reg hrs	Yes	Yes		
D9450	case presentation	No	No		
D9610	therapeutic parenteral drug-single admin	Yes	No		
D9612	therapeutic parenteral drug-2 or > admin	Yes	No	BR	
D9630	other drugs or meds	Yes	No		
D9910	application of desensitizing med	No	No		
D9911	application of desensitizing resin	No	No		
D9920	behavior management	Yes	No	BR	
D9930	treatment of complications-unusal circ	Yes	No	BR	
D9940	occlusal guard	No	No		
D9941	fabrication of athletic mouthguard	No	No		
D9942	repair/reline occlusal guard	No	No		
D9950	occlusion analysis	No	No		
D9951	occlusal adjustment-limited	No	No		
D9952	occlusal adjustment-complete	No	No		
D9970	enamel microabrasion	No	No		
D9971	odontoplasty	No	No		
D9972	external bleaching-per arch	No	No		
D9973	external bleaching-per tooth	No	No		
D9974	internal bleaching-per tooth	No	No		
D9999	unspecified adjunctive proc	Yes	No	BR	

## **410-123-1490 Hospital Dentistry**

(1) Hospital Dentistry is defined as routine dental services provided in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting under general anesthesia (or intravenous (IV) conscious sedation, if appropriate).

(2) The purpose of Hospital Dentistry is to provide safe, efficient dental care for clients who present special challenges requiring general anesthesia (or IV conscious sedation, if appropriate).

(3) The use of general anesthesia (or IV conscious sedation, if appropriate) is sometimes necessary to provide quality dental care for the client. Depending on the client, this can be done in an ASC, a day surgery center, outpatient hospital or inpatient hospital setting with the use of pre- and/or postoperative patient admission to the hospital.

(4) Refer to OAR 410-123-1060 for definitions of general anesthesia and conscious sedation.

(5) The need to diagnose and treat, as well as the safety of the client and the practitioner, must justify the use of general anesthesia (or IV conscious sedation, if appropriate). The decision to use general anesthesia or IV conscious sedation must take into consideration:

(a) Alternative behavior management modalities;

(b) Client's dental needs;

(c) Quality of dental care;

(d) Quantity of dental care;

(e) Client's emotional development;

(f) Client's physical considerations;

(g) Client's requiring dental care for whom the use of general anesthesia (or IV conscious sedation, if appropriate) may protect the developing psyche.

(6) Client, parental or guardian written consent must be obtained prior to the use of general anesthesia (or IV conscious sedation, if appropriate).

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

(a) Informed consent;

(b) Justification for the use of general anesthesia (or IV conscious sedation, if appropriate).

(8) Indications for the use of general anesthesia (or IV conscious sedation, if appropriate) for children 18 or younger are limited to:

(a) Children through age 3 with extensive dental needs;

(b) Children 4 years of age or older after treatment is attempted in the office setting with some type of sedation or nitrous oxide. If treatment in an office setting is not possible, documentation in the client's dental record as to why, in the estimation of the dentist, the client will not be responsive to office treatment;

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

(d) Requiring dental care for whom the use of general anesthesia (or IV conscious sedation) is to protect the developing psyche;

(e) Client who has sustained extensive orofacial or dental trauma;

(f) Physical, mental or medically compromising conditions;

(g) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate);

(h) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate).

(9) The intent to cover Hospital Dentistry in adults is limited to:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate);

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate);

(c) Client who has sustained extensive orofacial or dental trauma; or

(d) Clients who are medically fragile, have complex medical needs, contractures or other significant medical conditions potentially making the dental office setting unsafe for the client (not for the convenience of the client or the dentist) that prevent dental care without general anesthesia (or IV conscious sedation, if appropriate).

(10) Contraindications for Hospital Dentistry under general anesthesia (or IV conscious sedation, if appropriate):

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

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

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

(11) Hospital Dentistry requires prior authorization (PA) regardless of whether or not a client is enrolled in a Fully Capitated Health Plan (FCHP) or Dental Care Organization (DCO). All requests for PA require the DMAP 3301 form to be completed.

(12) Obtaining PA:

(a) If a client is enrolled in an FCHP and a DCO:

(A) The attending dentist is responsible for contacting the FCHP for PA requirements and arrangements when provided in an inpatient hospital, outpatient hospital or ambulatory surgical center;

(B) The attending dentist is responsible for submitting documentation to the FCHP and simultaneously to the DCO on the DMAP 3301 form;

(C) The medical and dental plans should review the DMAP 3301 form and raise any concerns they have to the other, in addition to contacting the attending dentist. This allows for mutual plan involvement and monitoring;

(D) The total response turn around time should not exceed 20 calendar days from the date of submission of all required documentation for routine dental care and should be processed according to the urgent/emergent dental care timelines;

(E) The FCHP is responsible for payment of all facility and anesthesia services. The DCO is responsible for payment of all dental professional services.

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

(A) The attending dentist is responsible for faxing the DMAP 3301 form and a completed ADA form to the Division of Medical Assistance Programs (DMAP) Dental Program Coordinator;

(B) DMAP is responsible for payment of facility and anesthesia services. The DCO is responsible for payment of all dental professional services.

(C) DMAP will issue a decision on PA requests within 30 days of receipt of the request.

(c) If a client is enrolled in an FCHP and is fee-for-service dental:

(A) The individual dentist is responsible for contacting the FCHP, obtaining PA and arrangement for Hospital Dentistry;

(B) It is the responsibility of the individual dentist to submit required documentation on the DMAP 3301 form to the FCHP;

(C) The FCHP is responsible for all facility and anesthesia services. DMAP is responsible for payment of all dental professional services.

(d) If a client is fee-for-service for both medical and dental:

(A) The individual dentist is responsible for faxing the DMAP 3301 form and a completed ADA form to the DMAP Dental Program Coordinator;

(B) DMAP is responsible for payment of all facility, anesthesia services and dental professional charges.

(13) DMAP will not approve any subsequent Hospital Dentistry requests without clinical documentation as to why the treatment plan provided, as outlined in the prior authorization request, was not completed.

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08

## **410-123-1540 Citizen/Alien-Waived Emergency Medical**

(1) The Citizen/Alien-Waived Emergency Medical (CAWEM) program provides treatment of emergency medical conditions, including delivery of newborns. CAWEM is defined in OAR 410-120-0000 and further explained in OAR 410-120-1200 of the Division of Medical Assistance Programs (DMAP) General Rules.

(2) People covered under the CAWEM program are NOT Oregon Health Plan clients. They DO NOT receive the Basic Benefit Package and ARE NOT enrolled into managed care plans. In the past, they have not received a DMAP Medical Care ID.

(3) Beginning March 1, 2000, people covered under the CAWEM program will receive a DMAP Medical Care ID, with the following message shown in the Benefit Package Section: "Coverage is limited to emergency medical services. Labor and delivery services for pregnant women are considered an emergency."

(4) Emergency services provided for anyone with a DMAP Medical Care ID displaying the above message should continue to be billed directly to DMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-123-1600 Managed Care Organizations**

(1) The Division of Medical Assistance Programs (DMAP) has contracted with Managed Care Organizations (MCO) and Primary Care Case Managers (PCCM) for medical services provided for clients under DMAP (Title XIX and Title XXI services). MCOs include Fully Capitated Health Plans (FCHP), Mental Health Organizations (MHO), Dental Care Organizations (DCO) and Chemical Dependency Care Organizations (CDO).

(2) Many Oregon Medical Assistance Program eligible clients are enrolled in one or more of these MCOs. Some clients that are not enrolled in an FCHP may be assigned a PCCM. Please see rule 410-123-1490 regarding Hospital Dentistry.

(3) DCOs are prepaid to cover dental services, including the professional component of any services provided in an ambulatory surgical care (ASC) facility, outpatient hospital or inpatient hospital setting for hospital dentistry.

(4) Services covered by an FCHP will not be reimbursed by DMAP, reimbursement is a matter between the FCHP and the provider. Emergent dental services do not require prior authorization from the FCHPs.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-123-1620 ICD-9-CM**

(1) ICD-9-CM diagnosis codes are not required for dental services submitted on an American Dental Association (ADA) form. If Oregon Administrative Rule (OAR) 410-123-1260 requires dental services to be billed on a CMS-1500 claim form, ICD-9-CM diagnosis codes are required.

(2) The appropriate code or codes from 001.0 through V82.9 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit. Diagnosis codes are required on all claims, including those submitted by independent laboratories and portable x-ray providers. Always provide the client's diagnosis to ancillary service providers when prescribing services, equipment and supplies.

(3) The principal diagnosis is listed in the first position; the principal diagnosis is the code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Up to three additional diagnoses codes may be listed on the claim for documented conditions that co-exist at the time of the encounter/visit and require or affect patient care, treatment, or management.

(4) The diagnosis codes must be listed using the highest degree of specificity available in the ICD-9-CM. A three-digit code is used only if it is not further subdivided. Whenever fourth or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. A code is invalid if it has not been coded to its highest specificity.

(5) DMAP requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards that are in effect for calendar years 2007 and 2008 for the date the service(s) was provided.

(a) For dental services, use codes on Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association;

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

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08

## **410-123-1640 Prescriptions**

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

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

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## **410-123-1670 OHP Standard Limited Emergency Dental Benefit**

(1) The definition of Dental Emergency is limited to section (2) in this rule for clients who are eligible for OHP Standard.

(2) The intent of the OHP Standard Limited Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth.

(3) Covered services are those procedures listed for the OHP Standard Benefit Package in OAR 410-123-1260 (Table 123-1260-1) and are limited to treatment for conditions such as:

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain;

(d) Tooth re-implantation when clinically appropriate; and

(e) Extraction of teeth, limited only to those teeth that are symptomatic.

(4) Hospital Dentistry is not a covered benefit for the OHP Standard population, with the following exceptions:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia; or

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia.

(5) Any limitations or prior authorization requirements on services listed in OAR 410-123-1260 will also apply to services in the OHP Standard benefit.

Stat. Auth.: ORS 409.050 and 414.065

Stats. Implemented: ORS 414.065

1-1-08