DHS Oregon Department of Human Services

**Health Services**
**Office of Medical Assistance Programs**

# Dental Services

# Rulebook

Includes:

1) Current Update Information (changes since last update)

2) Table of Contents

3) Complete set of Dental Services Administrative Rules

# Dental Services Program Rulebook

# Update Information

# for

# August 1, 2005

**Effective: August 1, 2005**

OMAP updated the DMEPOS Services Program Rulebook with the following rule revisions:

OMAP permanently amended OAR 410-123-1040 to remove incorrect language regarding billing and duplicative language. OMAP permanently amended OAR 410-123-1240 to reflect changes in OMAP's billing requirements for paper claims. Dental paper claim formats currently process using the Tartan System which has been set for decommission end of July 2005. DHS plans to process dental claims on an Optical Claims Reader (OCR) system. Currently OMAP is processing six different versions of dental claim forms (1994, 1996, 1998, 2000, 2002 and 2004). The OCR system will be programmed to process only the dental claim forms identified in 410-123-1240, effective August 1, 2005.

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

# DEPARTMENT OF HUMAN SERVICES

# MEDICAL ASSISTANCE PROGRAMS

# DIVISION 123

# DENTAL SERVICES

410-123-1000 Eligibility

410-123-1040 Foreword

410-123-1060 Definition of Terms

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

410-123-1100 Services Reviewed by the Office of Medical Assistance Programs (OMAP)

410-123-1160 Prior Authorization

410-123-1200 Services Not Considered Separate

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

Table 123-1260-1 Dental Fee-For-Service Rates

Table 123-1260-2 Maxillofacial Prosthetics Services

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 Emergency Dental Benefit

Table 123-1670-1 OHP Standard Dental Services

**410-123-1000 Eligibility**

(1) If you plan to bill the Office of Medical Assistance Programs (OMAP) for your services, be sure to verify eligibility before providing any service. It is the responsibility of the dentist to verify the client's eligibility. OMAP will not pay for services provided to an ineligible client even if services were authorized. Always check the client's OMAP Medical Care ID or call the Automated Information System (AIS) to verify eligibility.

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

(3) Billing of Third Party Resources:

(a) A third party resource (TPR) is an alternate insurance resource, other than OMAP, available to pay for medical services and items on behalf of Medical Assistance Program clients. If available to the client, this alternate insurance resource must be billed before OMAP can be billed. Indian Health Services or Tribal facilities are not considered 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 OMAP Medical Care ID, it means that the client has other resources that must be billed prior to billing OMAP.

(4) Fabricated Prosthetics: If a dentist 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 OMAP Medical Care ID, the dentist should use the date of impression as the date of service. This is the only exception to General Rules (OAR 410-120-1280). All other services must bill using the date the service was provided.

(5) 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 an OMAP Medical Care ID does not entitle a client to any services or consideration not provided to all clients.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065
10-1-03

**410-123-1040 Foreword**

(1) The Office of Medical Assistance Programs' (OMAP) Dental Services administrative rules establish specific requirements for dental services provided to OMAP clients and:

(a) Are designed to assist dentists, dental hygienists and denturists to deliver dental care services for clients with Medical Assistance Program coverage;

(b) Contain information on policy, services requiring prior authorization, service limitations and service criteria.

(2) All OMAP rules are intended to be used in conjunction with the OMAP General Rules (chapter 410, division 120), the Oregon Health Plan (OHP) Administrative Rules (chapter 410, division 141), Pharmaceutical Services Rules (chapter 410, division 121) and other relevant OMAP 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. Providers must follow OMAP rules in effect on the date of service.

(3) Dental services are limited as directed by General Rules – Excluded Services and Limitations (OAR 410-120-1200), the Dental Services administrative rules (chapter 410, division 123), and the Health Services Commission's (HSC) Prioritized List of Health Services (List) (found in the OHP Administrative Rules - chapter 410, division 141).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

8-1-05

**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.

(2) Citizen/Alien-Waived Emergency Medical (CAWEM) -- Persons only eligible for treatment of emergency medical conditions, including labor and delivery. Emergency medical treatment is merited for symptoms of such severity that absence of immediate medical attention would result in placing the patient's health in jeopardy, impairment to bodily functions, or serious dysfunction of a bodily organ or part.

(3) Conscious Sedation -- An induced controlled state of depressed consciousness, regardless of the route of administration of the anesthetic agent, in which the client retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

(4) Covered Services -- Services on the Health Services Commission's (HSC) Prioritized List of Health Services (List) that have been funded by the Legislature for clients receiving the Basic Health Care Package and those ancillary services necessary to perform the covered services.

(5) Deep Sedation -- An induced controlled state of depressed consciousness in which the client 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 client retains the ability to independently and continuously maintain an airway.

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

(7) Dental Hygienist with Limited Access Certification (LAC) -- A person licensed to practice dental hygiene with LAC pursuant to State law.

(8) 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 with LAC, or denture services provided within the scope of practice as defined under State law by a denturist.

(9) 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." Any other documentation requirements as outlined in the Dental Services billing and procedures rules.

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

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

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

(13) Emergency Dental Services:

(a) Covered services requiring immediate treatment. This includes services to treat:

(A) Acute infection;

(B) Acute abscesses;

(C) Severe tooth pain;

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

(E) Treat a tooth that has been knocked out.

(b) The emergency rule applies only to covered services. OMAP recognizes that some non-covered services may meet the criteria of emergency, but this rule does not extend to those non-covered services. Routine dental treatment or treatment of incipient decay does not constitute emergency care;

(c) Refer to OAR 410-123-1670 for the definition of an emergency and service coverage for OHP Standard clients;

(d) The following emergencies are not the responsibility of the dental provider unless they occur within the dental office or facility. Clients calling with these conditions should be referred to the emergency room or to call 911:

(A) Control hemorrhaging;

(B) Maintain an adequate airway; or

(C) Prevent life-threatening situations.

(14) General Anesthesia -- An induced controlled state of unconsciousness in which the client 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.

(15) Hospital Dentistry -- Dental services provided in an ambulatory surgical center, inpatient, or outpatient hospital setting.

(16) 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 client retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.

(17) Preventive Services -- Includes:

(a) Oral Prophylaxis (cleaning of teeth);

(b) Topical Fluoride;

(c) Sealants;

(d) Space maintenance; and

(e) Tobacco Counseling.

(18) Therapeutic Services -- Includes:

(a) Pulp therapy for permanent and primary teeth;

(b) Restorations for primary and permanent teeth using amalgam, composite materials and stainless steel or polycarbonate crowns;

(c) Scaling and curettage;

(d) Space maintainers for primary posterior teeth lost prematurely; and

(e) Removable prosthesis with inability to masticate.

(19) Dentally Appropriate: Refer to OAR 410-120-0000 for definition.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

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

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

(a) Clients enrolled in a Dental Care Organization are exempt from copyaments. 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 copyaments 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

04-01-05

**410-123-1100 Services Reviewed by the Office of Medical Assistance Programs (OMAP)**

(1) The Office of Medical Assistance Programs (OMAP) 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) Rampant caries should be arrested and a period of adequate oral hygiene, as defined by the provider, demonstrated, before dental prosthetics are proposed.

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

(4) 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 an OMAP dental consultant.

(5) Treatment Justification: OMAP may request the treating dentist to submit appropriate radiographs or other clinical information which justifies the treatment:

(a) Before issuing PA;

(b) In the process of utilization review; or

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-02

## 410-123-1160 Prior Authorization

(1) Prior authorization (PA) requirements for services and supplies listed in the Dental Services provider guide are intended for clients who are not enrolled in a dental care organization. Contact the client's dental care organization for their policy governing PA requirements.

(2) PA for routine dental services in an Ambulatory Surgical Center (ASC), outpatient or inpatient setting is required. Routine dental services are defined as those dental services that are routinely done in the office setting but due to specific client need, meet guidelines from the American Dental Association and the American Academy of Pediatric Associations for hospital dentistry. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(3) 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.

(4) PA for some maxillofacial surgeries may be required. Refer to the current Medical Surgical Services guide for information.

(5) If a client is enrolled in a Fully Capitated Health Plan (FCHP), that FCHP may require PA for ASC, outpatient or inpatient dental services. It is the responsibility of the provider to check with the FCHP for any required authorization prior to the service being rendered.

(6) 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 by:

(a) Checking the client's Office of Medical Assistance Programs (OMAP) Medical Care ID or;

(b) Confirming eligibility through the Automated Information System (AIS); or

(c) Contacting the local branch office.

(7) When radiographs are required they must be:

(a) Readable copies;

(b) Mounted or loose;

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

(d) Clearly labeled with dentist's name and address and client's name.

(8) Do not send in radiographs unless required by Dental Services rules or requested.

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

(10) Send requests for PA to: Dental Program Coordinator -- OMAP.

(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 number.

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-02

## 410-123-1200 Services Not Considered Separate

The following services do not warrant an additional fee and are considered to be either minimal, included in the examination, part of another service, or included in routine post-op or follow-up care:

(1) Alveolectomy/Alveoloplasty in conjunction with extractions.

(2) Cardiac and other monitoring.

(3) Curettage and root planing -- per tooth.

(4) Diagnostic casts.

(5) Dietary counseling.

(6) Direct pulp cap.

(7) Discing.

(8) Dressing change.

(9) Electrosurgery.

(10) Equilibration.

(11) Gingival curettage -- per tooth.

(12) Gingivectomy/gingivoplasty -- per tooth.

(13) Indirect pulp cap.

(14) Local anesthesia.

(15) Medicated pulp chambers.

(16) Occlusal adjustments.

(17) Occlusal analysis.

(18) Odontoplasty.

(19) Oral hygiene instruction.

(20) Peridontal charting, probing.

(21) Polishing fillings.

(22) Post extraction treatment for alveolaritis (dry socket treatment) if done by the provider of the extraction.

(23) Pulp vitality tests.

(24) Smooth broken tooth.

(25) Special infection control procedures.

(26) Surgical procedure for isolation of tooth with rubber dam.

(27) Surgical splint.

(28) Surgical stent.

(29) Suture removal.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-02

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

The following general categories of Dental Services are not funded on the Health Services Commission's (HSC) Prioritized List of Health Services (List) and are not covered for any client:

(1) Desensitization;

(2) Implant and implant services;

(3) Mastique or veneer procedure;

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

(5) Overhang removal;

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

(7) Temporomandibular Joint Dysfunction treatment;

(8) Tooth bleaching;

(9) 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 List of Prioritized Services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-03

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

(1) Providers are not permitted to bill and accept payment from the Office of Medical Assistance Programs (OMAP) 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 OMAP or plan contract. If a client wants to purchase a non-covered service or item, they must be responsible for full payment. OMAP 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

10-1-02

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

(1) The Office of Medical Assistance Programs (OMAP) will only accept claims for professional dental services, in the following formats:

(a) Electronic claims – the "837" dental electronic claim format is used for all professional dental services provided in any setting:

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

(B) The "835" professional electronic claim format is used when billing for any service identified in OAR 410-123-1260 or in Table 123-1260-2.

(b) Paper claims:

(A) ADA paper claims (only the 2000, 2002 and 2004 versions) – this format is used for all professional dental services provided in any setting;

(B) Effective August 1, 2005, claims received by OMAP that are not in the correct format will be returned to the provider unprocessed;

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

(D) CMS-1500 paper claim format must be used when billing for any service identified in OAR 410-123-1260 or in Table 123-1260-2.

(2) Specific information regarding HIPAA requirements can be found on OMAP's website.

(3) Refer to the Dental Supplemental Materials for information regarding OMAP forms.

(4) Do not include OMAP copayments when billing for dental services.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-05

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

(1) Refer to Table 123-1260-1 for information regarding dental services requiring prior authorization and surgical report:

(a) Procedure codes listed in Table 123-1260-1 are subject to change without notification;

(b) Services funded on the Health Services Prioritized List of Health Services may change and not reflected in OARs 410-123 until the following rule change period.

(2) The client's records must include appropriate documentation to support the service and level of care rendered.

(3) Dental services that are not dentally appropriate or are for the convenience of the client is not covered:

(4) Restorative treatments are limited:

(a) When prognosis is unfavorable;

(b) When treatment impractical;

(c) Until rampant caries are arrested; or

(d) A lesser-cost procedure would achieve the same ultimate result.

(5) Exams:

(a) Codes are based on the American Dental Association CDT-5, except where noted for restorations. Refer to the CDT-5 publication for code descriptions;

(b) For services billed that do not require a tooth number or surface, leave blank;

(c) Exams (billed as D0120, D0150, D0160 or D0180) by the same practitioner are payable once every twelve months;

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

(6) Radiographs:

(a) Routine radiographs are limited to once every 12 months, except panoramic (D0330) and intraoral complete series (D0210) which are payable once every five years. 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. A maximum of six radiographs are payable for any one emergency;

(b) When billing for radiographs, do not use tooth number or tooth surface;

(c) The minimum age for billing code D0210 is six years. For clients under age six, radiographs may be billed separately 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 services are:

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

(B) There is a minimum of 10 periapicals and four bitewings for a total of 14 films for ages 12 and older.

(e) If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), the Office of Medical Assistance Programs (OMAP) will pay for complete series;

(f) Bitewing radiographs for routine screening are payable every 12 months;

(g) Payment for routine panoramic films or complete series intraoral radiograph is limited to one every five years. This does not mean that panoramic or complete series intraoral radiographs can both be done within a five-year period. Additional films are covered when medically justified, e.g., fractures;

(h) Payment for some or all-multiple radiographs of the same tooth or area may be denied if OMAP determines the number to be excessive;

(i) Note: When billing additional films (D0230 and D0260), do not use a separate line for each additional film. Use only one line: add up the total additional films being billed and enter this number under the Quantity column, or create a "Q" column, depending on which form you use.

(7) 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 (Office Procedure) is limited to once every 12 months. Additional topical fluoride treatments may be available for a client up to a total of 4 treatments within a 12- month period:

(A) Additional topical fluoride provisions may be available for persons with high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;

(B) Who is pregnant with high-risk oral condition 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 is six years or younger with high-risk oral health factors.

(c) Sealants:

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

(B) Limited to one treatment per tooth every five years except for visible evidence of clinical failure.

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

(8) Tobacco Cessation:

(a) Use CDT-5 code D1320 on an American Dental Association (ADA) claim form when billing for tobacco cessation services as outlined. Maximum of 10 services within a three-month period;

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

(9) Restorations -- Amalgam and Composite:

(a) Payment for restorations is limited to the maximum restoration fee of four surfaces per tooth. Refer to American Dental Association Current Dental Terminology 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 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.

(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 will not be covered in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason.

(11) Endodontics:

(a) Pulp Capping: Direct and indirect pulp caps are included in the restoration fee -- no additional payment will be made;

(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 prosthedonitcs,

(B) 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;

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

(D) Root canal therapy is not covered for third molars.

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

(12) Periodontics:

(a) When billing for quadrants, use Health Insurance Portability and Accountability Act (HIPAA) compliant codes;

(b) D4210 -- covered for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., dilantin hyperplasia;

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

(d) D4341 -- 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;

(e) D4910 -- 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;

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

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

(h) Note: The Office of Medical Assistance Programs (OMAP) will not reimburse for the following procedures if performed on the same date of service:

(A) D1110;

(B) D1120;

(C) D4210;

(D) D4220;

(E) D4260;

(F) D4341;

(G) D4355;

(H) D4910.

(13) Removable Prosthodontics:

(a) Removable cast metal prosthodontics and full dentures are limited to clients 16 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 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 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, 2000, while FFS and a year later enrolls in a DCO. The client would not be eligible for another full denture until February 2, 2005, 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 the Office of Medical Assistance Programs (OMAP) using CPT or HCPCS codes on a CMS-1500 listed in Table 123-1260-2. Payment is based on the physician fee schedule.

(15) Oral Surgery:

(a) Oral surgical services performed in a dental office setting 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) Oral surgical services performed in a dental office setting are billed on an American Dental Association (ADA) dental claim form. For clients enrolled in a Dental Care Organization (DCO), the oral surgical services are the responsibility of the DCO;

(c) Oral surgical services performed in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting and related anesthesia services require PA. Oral surgical procedures directly related to the teeth and supporting structures must be billed on an ADA claim form;

(d) If the services requiring hospital dentistry are the result of a medical condition/diagnosis (i.e., fracture, cancer), use appropriate American Medical Association (AMA) CDT-5 procedure codes and bill procedures on a CMS-1500 claim form. For clients enrolled in a Fully Capitated Health Plan (FCHP), the facility charge and anesthesia services are the responsibility of the FCHP. See rule 410-123-1490 Hospital Dentistry for requirements;

(e) All codes listed as By Report require an operative report;

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

(g) Surgical Assistance:

(A) Reimbursement for surgical assistance is restricted to services provided by dentists and physicians;

(B) Surgical assistance will be reimbursed only when the assistant's services qualify as a dental or medical necessity;

(C) Only one surgical assistant will be reimbursed unless clinical justification is submitted for an additional assistant;

(D) Primary surgeons, assistant surgeons, anesthesiologists, and nurse anesthetists not in common practice must bill separately for their services.

(h) Extractions -- Includes local anesthesia and routine postoperative care;

(i) Surgical Extractions:

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

(B) The following codes are limited to treatment for symptomatic pain, infection, bleeding, or swelling:

(i) D7220;

(ii) D7230;

(iii) D7240;

(iv) D7241 -- By Report;

(v) D7250.

(j) Note: The following procedures on the Health Services Commission's (HSC) Prioritized List of Health Services (List) are covered as medical procedures. Bill on a CMS-1500, using CPT coding. If a client is enrolled in

a Fully Capitated Health Plan (FCHP) it is the responsibility of the provider to contact the FCHP for any required authorization before the service is rendered:

(A) D7430;

(B) D7431;

(C) D7460;

(D) D7461;

(E) D7810;

(F) D7820;

(G) D7830.

(16) Orthodontia:

(a) Orthodontia services are limited to eligible clients for the ICD-9-CM diagnosis of cleft palate with cleft lip;

(b) Prior authorization (PA) is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate/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. 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 the Office of Medical Assistance Programs (OMAP) 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, and D9240);

(b) General anesthesia is paid using D9220 for the first 30 minutes and use D9221 for each additional 15-minute period, up to three hours on the same day of service. When using D9221, 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) IV sedation is paid per date of service;

(e) 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.

(f) Upon request, providers must submit to the Office of Medical Assistance Programs (OMAP) a copy of their permit to administer anesthesia, analgesia and/or sedation;

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

(18) D9430 is limited to three visits per year.

Table 123-1260-1

Table 123-1260-2

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

04-01-05

## Table 123-1260-1 Dental Fee-For-Service Rates

- Codes listed in this table are covered services for OHP Plus only. Refer to Table 123-1670-1 for a list of services included in the OHP Standard Emergency Benefit.
- Dental services billed on a CMS-1500 using CPT or HCPCS codes are reimbursed on the physician fee schedule.
- Codes that are not priced 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.
- Codes with * require Prior Authorization (PA).
- Codes in bold and italics do not require a copayment for adult clients with a dental benefit in fee-for-service.

| | | | |
|---|---|---|---|
| ***D0120*** | ***$23.23*** | ***D0472*** | ***$34.28*** |
| ***D0140*** | ***$30.97*** | ***D0473*** | ***$34.28*** |
| ***D0150*** | ***$36.14*** | ***D0474*** | ***$34.28*** |
| ***D0160*** | ***$62.09*** | ***D0480*** | ***$34.28*** |
| ***D0170*** | ***$24.16*** | ***D0502*** | ***BR*** |
| ***D0180*** | ***36.14*** | D1110 | $36.50 |
| ***D0210*** | ***$29.99*** | D1120 | $28.06 |
| ***D0220*** | ***$9.27*** | D1201 | $36.71 |
| ***D0230*** | ***$5.36*** | D1203 | $12.73 |
| ***D0240*** | ***$4.28*** | D1320 | $10.00 |
| ***D0250*** | ***$18.21*** | D1351 | $18.96 |
| ***D0260*** | ***$13.93*** | D1510 | $74.98 |
| ***D0270*** | ***$5.36*** | D1515 | $96.41 |
| ***D0272*** | ***$10.71*** | D1520 | $72.84 |
| ***D0274*** | ***$12.85*** | D1525 | $86.77 |
| ***D0277*** | ***$22.26*** | D1550 | $26.78 |
| ***D0290*** | ***$19.28*** | D2140 | $36.37 |
| ***D0310*** | ***Manual*** | D2150 | $45.74 |
| ***D0320*** | ***Manual*** | D2160 | $55.67 |
| ***D0321*** | ***$20.35*** | D2161 | $63.27 |
| ***D0322*** | ***Manual*** | D2330 | $38.56 |
| ***D0330*** | ***$22.50*** | D2331 | $52.39 |
| ***D0340*** | ***$17.14*** | D2332 | $66.87 |
| ***D0350*** | ***$20.80*** | D2335 | $81.19 |
| ***D0415*** | ***Manual*** | D2390 | $72.80 |

| | | | |
|---|---|---|---|
| D2710 | $59.99 | D4341 | $62.01 |
| D2721* | $192.82 | D4342 | $46.50 |
| D2722* | $224.95 | D4355 | $48.20 |
| D2751* | $257.09 | D4910 | $32.14 |
| D2752* | $267.80 | D4920 | BR |
| D2910 | $26.78 | D5110* | $348.14 |
| D2920 | $26.78 | D5120* | $348.14 |
| D2930 | $71.79 | D5130* | $348.14 |
| D2931 | $75.49 | D5140* | $348.14 |
| D2932 | $59.99 | D5213* | $348.14 |
| D2933 | $64.27 | D5214* | $348.14 |
| D2940 | $28.84 | D5410 | $18.21 |
| D2950 | $48.20 | D5411 | $18.21 |
| D2951 | $21.80 | D5421 | $19.28 |
| D2954 | $64.27 | D5422 | $19.28 |
| D2955 | Manual | D5510 | $32.14 |
| D2957 | $64.27 | D5520 | $32.14 |
| D2970 | $44.99 | D5610 | $32.14 |
| D2980 | Manual | D5620 | $32.14 |
| D3220 | $48.33 | D5630 | $53.56 |
| D3221 | $46.06 | D5640 | $32.14 |
| D3230 | $46.06 | D5650 | $32.14 |
| D3240 | $46.06 | D5660 | $48.20 |
| D3310 | $144.61 | D5710 | $170.56 |
| D3320 | $166.04 | D5711 | $170.56 |
| D3330 | $208.88 | D5720 | $170.56 |
| D3331 | $260.00 | D5721 | $170.56 |
| D3332 | Manual | D5730 | $32.14 |
| D3333 | Manual | D5731 | $32.14 |
| D3351 | $107.12 | D5740 | $32.14 |
| D3352 | $53.56 | D5741 | $32.14 |
| D3353 | Manual | D5750 | $107.12 |
| D3430 | Manual | D5751 | $107.12 |
| D3950 | $80.34 | D5760 | $107.12 |
| D4210 | $52.00 | D5761 | $107.12 |
| D4240 | $53.56 | D5820 | $152.00 |
| D4241 | $40.71 | D5821 | $158.08 |
| D4245 | $64.27 | D5850 | $27.85 |
| D4260 | $314.81 | D5851 | $27.85 |
| D4261 | $236.10 | D5911 | Manual |
| D4268 | $64.27 | D5912 | Manual |

| | | | |
|---|---|---|---|
| D5913 | Manual | D7250 | $115.36 |
| D5915 | Manual | D7260 | $96.41 |
| D5916 | Manual | D7270 | $64.27 |
| D5919 | Manual | D7285 | Manual |
| D5922 | Manual | D7286 | $48.20 |
| D5923 | Manual | D7287 | Manual |
| D5924 | Manual | D7288 | Manual |
| D5925 | Manual | D7320 | $37.49 |
| D5926 | Manual | D7340 | Manual |
| D5928 | Manual | D7350 | Manual |
| D5929 | Manual | D7440 | Manual |
| D5931 | Manual | D7441 | Manual |
| D5932 | Manual | D7450 | $165.75 |
| D5933 | Manual | D7451 | Manual |
| D5934 | Manual | D7471 | $37.49 |
| D5935 | Manual | D7490 | Manual |
| D5936 | Manual | D7510 | $66.95 |
| D5937 | Manual | D7511 | Manual |
| D5951 | Manual | D7520 | $40.71 |
| D5952 | $428.48 | D7521 | Manual |
| D5953 | Manual | D7530 | $85.70 |
| D5954 | Manual | D7540 | Manual |
| D5955 | $428.48 | D7550 | Manual |
| D5958 | Manual | D7560 | Manual |
| D5959 | Manual | D7610 | Manual |
| D5960 | Manual | D7620 | Manual |
| D5983 | Manual | D7630 | Manual |
| D5984 | Manual | D7640 | Manual |
| D5985 | Manual | D7650 | Manual |
| D5986 | Manual | D7660 | Manual |
| D5987 | Manual | D7670 | $331.90 |
| D6930 | $44.99 | D7680 | Manual |
| D6972* | $64.27 | D7710 | Manual |
| D6980 | Manual | D7720 | $62.13 |
| D7111 | $30.00 | D7730 | Manual |
| D7140 | $75.19 | D7740 | Manual |
| D7210 | $85.70 | D7750 | Manual |
| D7220 | $92.70 | D7760 | Manual |
| D7230 | $125.66 | D7770 | Manual |
| D7240 | $154.50 | D7780 | Manual |
| D7241 | BR | D7910 | $62.40 |

| | | | |
|---|---|---|---|
| D7911 | $93.60 | D8660* | Manual |
| D7912 | $135.20 | D8670* | Manual |
| D7920 | Manual | D8680* | Manual |
| D7950 | BR | D8690* | Manual |
| D7970 | $64.27 | D8999* | Manual |
| D7980 | Manual | D9110 | $44.29 |
| D7981 | BR | D9211 | Manual |
| D7982 | Manual | D9212 | $26.78 |
| D7983 | Manual | D9220 | $117.83 |
| D7990 | Manual | D9221 | $28.92 |
| D7997 | Manual | D9230 | $8.57 |
| D8010* | Manual | D9241 | $108.15 |
| D8020* | Manual | D9242 | Manual |
| D8030* | Manual | D9248 | $75.00 |
| D8040* | Manual | D9310 | $26.78 |
| D8050 | Manual | D9420 | $107.12 |
| D8060* | Manual | D9430 | $8.57 |
| D8070* | Manual | D9440 | $35.35 |
| D8080* | Manual | D9610 | $12.85 |
| D8090* | Manual | D9630 | $41.20 |
| D8210* | Manual | D9930 | BR |
| D8220* | Manual | D9999 | BR |

## Table 1260-2 Maxillofacial Prosthetics Services

The following codes must be billed using CPT or HCPCS coding on a CMS 1500 claim form.

| | |
|---|---|
| D5911 | D5935 |
| D5912 | D5936 |
| D5913 | D5937 |
| D5915 | D5951 |
| D5916 | D5952 |
| D5919 | D5953 |
| D5922 | D5954 |
| D5923 | D5955 |
| D5924 | D5958 |
| D5925 | D5959 |
| D5926 | D5960 |
| D5928 | D5983 |
| D5929 | D5984 |
| D5931 | D5985 |
| D5932 | D5986 |
| D5933 | D5987 |
| D5934 | |

**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.

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

(3) The use of general anesthesia 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) General anesthesia is a controlled state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal command.

(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. The decision to use general anesthesia 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 may protect the developing psyche.

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

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

(a) Informed consent;

(b) Justification for the use of general anesthesia.

(8) Indications for the use of general anesthesia for children 18 or younger is limited to:

(a) If a child is under 3 years old with extensive dental needs;

(b) If a child is over 3 years old, 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 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;

(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.

(10) 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;

(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;

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

(11) Contraindications for general anesthesia:

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

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

(c) Medical contraindication to general anesthesia.

(a) (12) 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 OMAP 3301 form to be completed.

(13) 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 OMAP 3301 form;

(C) The medical and dental plans should review the OMAP 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 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 OMAP 3301 form and a completed ADA form to the Office of Medical Assistance Programs (OMAP) Dental Program Coordinator;

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

(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 OMAP 3301 form to the FCHP;

(C) The FCHP is responsible for all facility and anesthesia services. OMAP 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 OMAP 3301 form and a completed ADA form to the OMAP Dental Program Coordinator;

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

(14) OMAP 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

Stats. Implemented: ORS 414.065

10-1-04

## 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 OMAP 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 an Office of Medical Assistance Programs (OMAP) Medical Care ID.

(3) Beginning March 1, 2000, people covered under the CAWEM program will receive an OMAP 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 an OMAP Medical Care ID displaying the above message should continue to be billed directly to OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-02

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

(1) The Office of Medical Assistance Programs (OMAP) has contracted with Managed Care Organizations (MCO) and Primary Care Case Managers (PCCM) for medical services provided for clients under OMAP (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 OMAP, 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

10-1-02

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

(1) Diagnosis codes are not required for dental claims submitted on an American Dental Association (ADA) form. Diagnosis codes are required for dental services that require by rule to be submitted on a CMS-1500 claim form.

(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-digit subcategories and/or fifth-digit subcategories are provided, they must be assigned. A code is invalid if it has not been coded to its highest specificity.

(5) The Office of Medical Assistance Programs (OMAP) requires accurate coding and applies the national standards that are in effect for Calendar Year 2003 and 2004 set by the ADA, the American Hospital Association and the American Medical Association. OMAP has unique coding and claim submission requirements for Administrative Examinations; specific diagnosis coding instructions are provided in the Administrative Examination Rules which is available on OMAP's website.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-03

**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

10-1-03

**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 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) Services are limited to those procedures listed in Table 123-1670-1 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 are limited only to those teeth that are symptomatic.

(4) Hospital Dentistry is not a covered benefit for the OHP Standard population except:

(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.

Table 123-1670-1

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065 04-01-05

**Table 123-1670-1 OHP Standard Limited Emergency Dental Services (Effective August 1, 2004)**

Codes listed in this table are covered services for OHP Standard Limited Dental Emergency Benefit.

| Code | |
|---|---|
| D0140 | D7140 |
| D0170 | D7210 |
| D0220 | D7220 |
| D0230 | D7230 |
| D0240 | D7240 |
| D0250 | D7241 |
| D0260 | D7250 |
| D0270 | D7260 |
| D0272 | D7270 |
| D0330 | D7510 |
| D2910 | D7520 |
| D2920 | D7911 |
| D2940 | D9110 |
| D3110 | D9210 |
| D3220 | D9215 |
| D3221 | D9230 |
| D6930 | D9410 |
| D7111 | D9420 |
| | D9440 |