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

FILING CAPTION: Division 123 Dental Program Rules Update

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RULES:
410-123-1000, 410-123-1025, 410-123-1060, 410-123-1100, 410-123-1160, 410-123-1220, 410-123-1240, 410-123-1260, 410-123-1265

AMEND: 410-123-1000

RULE TITLE: Eligibility, Services Reviewed by the Division, Billing and the Dental Billing Invoice

NOTICE FILED DATE: 10/15/2020

RULE SUMMARY: Rule 410-123-1000 defines: (1) Oral health provider responsibilities to verify eligibility and Medicaid service limits of recipient before the rendering of services, (2) procedures for the billing and payment of Medicaid covered dental services, (3) financial and clinical records documentation mandates, and (3) gives reference to the new online data base of covered and non-covered dental services. This rule protects the Oregon Health Authority (OHA) and oral health providers from claim denials related to eligibility and billing.

RULE TEXT:
(1) Eligibility:
(a) Providers are responsible for verification of client eligibility and must do so before providing any service or billing the Oregon Health Authority, Health Systems Division (Division) or any Oregon Health Plan (OHP) Managed Care Entitiy (MCE);
(b) The Division may not pay for services provided to an ineligible client even if services were authorized. Refer to General Rules OAR 410-120-1140 (Verification of Eligibility) for details.
(2) Services Reviewed by the Health Services Division (Division):
(a) Services requiring prior authorization (PA): See OAR 410-123-1160 and 410-120-1320 for information about services that require PA or how to request PA.
(b) By Report Procedures:
(A) Request for payment for dental services listed as “by report” (BR) must be submitted with a full description of the procedure, including relevant operative or clinical history reports and/or radiographs. Payment for BR procedures will be approved in consultation with a Division dental consultant;
(B) Refer to the “Covered and Non-Covered Dental Services” data base, as referenced in OAR 410-123-1260, for a list

of procedures noted as BR. See OAR 410-123-1220.
(3) Billing:
(a) Providers must follow the Division rules in effect on the date of service. All Division rules are intended to be used in conjunction with the Division's General Rules Program (chapter 410, division 120), the OHP Administrative Rules (chapter 410, division 141), Pharmaceutical Services Rules (chapter 410, division 121) and other relevant Division OARs applicable to the service provided, where the service is delivered, and the qualifications of the person providing the service including the requirement for a current signed provider enrollment agreement;
(b) Providers must comply with OAR 410-120-1280 Billing rules and OAR 410-120-1360 requirements to develop and maintain adequate financial and clinical records and other documentation that supports the specific care, items, or services for which payment has been requested;
(A) Authority will only pay for services that are adequately documented.
(B) Documentation must support the dates of service, the amounts billed, the specific services provided, who provided the services, and the medical necessity of those services.
(C) Financial records must indicate that the amount billed to the Authority was appropriate and that all other resources were pursued before billing the Authority.
(D) FFS providers must keep clinical information on file for seven years, and financial records five years. Providers contracted with an MCE must retain all clinical records for a minimum of ten (10) years after the date of services for which claims are made, OAR 410-141-3520. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the retention period, the clinical records must be retained until all issues arising out of the action are resolved.
(c) Third Party Resources: A third party resource (TPR) is an alternate insurance resource, other than the Division, available to pay for medical/dental services and items on behalf of OHP clients. Any alternate insurance resource must be billed before the Division or any OHP MCE can be billed. Indian Health Services or Tribal facilities are not considered to be a TPR pursuant to the Division's General Rules Program rule 410-120-1280;
(d) For Medicaid covered services, the provider must not:
(A) Bill the Authority more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Authority program rules;
(B) Bill the client for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Authority;
(C) Bill the client for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, prior authorization not obtained, etc.);
(e) For Non-covered services: Before the provider provides the non-covered service, the client must sign the provider-completed Agreement to Pay (OHP 3165) in Table 3165 of OAR 410-120-1280 Billing rule. The completed OHP 3165 is valid only if dated and signed by the client prior to service(s) being delivered, the estimated fee does not change, and the service is scheduled within 30 days of the client's signature. Providers must make a copy of the completed OHP 3165 form available to the Authority or MCE upon request;
(f) Co-payments for OHP clients may be required for certain services. See General Rules OAR 410-120-1230 for specific information on co-pays;
(g) Refer to OAR 410-123-1160 for information regarding dental services requiring prior authorization (PA);
(h) The client's records must include documentation to support the appropriateness of the service and level of care rendered;
(i) The Division shall only reimburse for dental services that are dentally appropriate as defined in OAR 410-123-1060;
(j) Refer to OAR chapter 410, division 147 for information about reimbursement for dental services provided through a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC);
(k) Treatment Plans: Being consistent with established dental office protocol and the standard of care within the community, scheduling of appointments is at the discretion of the dentist. The agreed upon treatment plan established by the dentist and patient shall establish appointment sequencing. Eligibility for medical assistance programs does not

entitle a client to any services or consideration not provided to all clients.
(4) Billing Invoice:
(a) Providers: Refer to the Dental Services Provider Guide for information regarding claims submissions and billing information.
(b) Providers billing dental services on paper must use the 2019 version of the American Dental Association (ADA) claim form.
(c) Submission of electronic claims directly or through an agent must comply with the Electronic Data Interchange (EDI) rules. OAR 943-120-0100 et seq.
(d) Specific information regarding Health Insurance Portability and Accountability Act (HIPAA) requirements can be found on the Division Web site.
(e) Providers will not include any client co-payments on the claim when billing for dental services.
(f) Upon submission of a claim to the Authority for payment, the provider agrees that it has complied with all Authority program rules and understands that payment of the claim will be from federal and state funds, and that any falsification, or concealment of material fact, may be prosecuted under federal and state laws. Submission of a claim or encounter does not relieve the provider from the requirement of a signed provider enrollment agreement.
(5) A provider enrolled with the Authority must bill using the Authority assigned provider number, or the National Provider Identification (NPI) number, pursuant to OAR 410-120-1260;
(6) Unless otherwise specified, claims must be submitted after:
(a) Delivery of service; or
(b) Dispensing, shipment or mailing of the item.
(7) The provider must submit true, accurate and complete information when billing the Division. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted information;
(a) A claim is considered a valid claim only if it contains all data required for processing. See the appropriate provider rules and supplemental information for specific instructions and requirements;
(b) A provider or its contracted agency, including billing providers, may not submit or cause to be submitted:
(A) Any false claim for payment;
(B) Any claim altered in such a way as to result in a payment for a service that has already been paid;
(C) Any claim upon which payment has been made or is expected to be made by another source until after the other source has been billed, with the exception of OAR 410-120-1280(10)(c)(A-D). If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to the Authority. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate TPR Explanation Code in box 9 of the appropriate claim form or in the appropriate field if electronically submitted in a manner authorized;
(D) Any claim for furnishing specific care, items, or services that has not been provided;
(E) Any claim for specific care, items or services that is not supported by the documentation, the member’s treatment or care plan, as applicable, and compliant with program specific rules. All documentation must be complete and signed by the rendering provider prior to submitting a claim the Authority or MCE for payment.
(c) If an overpayment has been made by the Authority, the provider is required to do one of the following within 30 calendar days of the date on which the overpayment was identified:
(A) Adjust the original claim to show the overpayment as a credit in the appropriate field; or
(B) Submit an Individual Adjustment Request (OHP 1036); or
(C) Adjust the claim on the Provider Web Portal available online at all times at: https://www.or-medicaid.gov; or
(D) Refund the amount of the overpayment on any claim; or
(E) Void the claim via the Provider Web Portal if the Authority overpaid due to erroneous billing;
(F) If the overpayment occurred because of a payment from a third party payer refer to OAR 410-120-1280(10)(f) Billing rule.
(8) Procedure code requirement:
(a) For claims requiring a procedure code the provider must bill as instructed in the appropriate Authority program rules

and must use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-PCS, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided;
(b) For claims that require the listing of a procedure code as a condition of payment, the reported procedure code must be supported by the client's medical record and the codes that most accurately describes the services provided. All providers, including Hospitals, billing the Authority must follow national coding guidelines;
(c) When there is no appropriate descriptive procedure code to bill the Authority, the provider must use the code for "unlisted services." A complete and accurate description of the specific care, item, or service must be documented on the claim;
(d) Where there is one CPT, CDT, or HCPCS code that according to CPT, CDT, and HCPCS coding guidelines or standards describes an array of services, the provider must bill the Authority using that code rather than itemizing the services under multiple codes. Providers may not "unbundle" services.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

ADOPT: 410-123-1025

RULE TITLE: Program Integrity and Provider Audits

NOTICE FILED DATE: 10/15/2020

RULE SUMMARY: The creation of OAR 410-123-1025 brings oral health programs into compliance with Oregon's State Plan Amendment and current federal program integrity and audit rules and regulations. Language in 410-123-1025 references the Oregon Health Authority's (OHA) financial responsibility for any improper payments identified through program integrity activities. The rule ensures that all oral health programs meet federal requirements for program integrity efforts through clinical record maintenance, and prompt reporting of suspected fraud, waste and abuse of Oregon's Medicaid program.

RULE TEXT:

(1) The Oregon Health Authority (Authority) uses several approaches to promote program integrity and preventing fraud, waste and abuse in the Medicaid program. OAR 410-120-1360 through 410-120-1580 generally describe Authority program integrity activities related to Medicaid providers and payment. Providers enrolled with the Authority or under contract with the Authority or the Department of Human Services (DHS) receiving payments from the Authority or DHS are subject to audit or other post payment review procedures for all payments applicable to items or services furnished or supplied by the provider to or on behalf of Authority or DHS clients.

(2) Providers must comply with OAR 410-120-1510, OAR 461-195-0601 and the requirements therein for prompt reporting of fraud, waste and abuse in the Medicaid program:

(a) Providers must report all suspected fraud, waste and abuse by a provider, including fraud, waste or abuse by its employees or in the Authority administration, to the Medicaid Fraud Control Unit (MFCU) of the Department of Justice (DOJ) or to the Authority's Office of Program Integrity (OPI). Information on how to report may be found online at all times: https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx.

(b) Providers must report all suspected fraud or abuse by an Authority or DHS client to the DHS's Office of Payment and Recovery (OPAR) Fraud Investigations Unit (FIU). Information on how to report may be found online at all times: http://www.oregon.gov/OHA/HSD/OHP//Pages/Policy-General-Rules.aspx.

(c) Authority will take all actions necessary to investigate and respond to credible allegations of fraud, waste and abuse in the Medicaid program, including but not limited to suspending or terminating the provider from participation in the medical assistance programs, withholding payments or seeking recovery of payments made to the provider, or imposing other sanctions provided under OAR 410-120-1400, state laws or regulations. These actions and any outcome(s) will be reported to CMS, or other federal or state of Oregon entities, or law enforcement, as appropriate.

(3) Providers delivering goods or services to OHP members and receiving payment under Oregon's medical assistance programs may be audited by the Authority, MFCU, Oregon Secretary of State, the Department of Health and Human Services (DHHS), or their authorized representatives.

(a) The audit rules and procedures applicable to oral health providers and MCE participating providers are in OAR 410-120-1396. The Authority conducts periodic audits of providers to ensure proper payments are made based on requirements applicable to covered services, to ensure program integrity of the Authority or DHS medical programs as outlined in OAR 410-120-1260 and OAR 407-120-0310, recover overpayments and uncover possible instances of fraud, waste, and abuse.

(b) Providers must submit true, accurate, and complete claims and encounters to the Authority. The Authority treats the submission of a claim or encounter, whether on paper or electronically, as certification by the provider of the following: "This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim or encounter will be from federal and state funds, and that any falsification or concealment of a material fact maybe prosecuted under federal and state laws."

(c) Providers must maintain clinical, financial and other records, capable of being audited or reviewed, consistent with the requirements of OAR 410-120-1360 Requirements for Financial, Clinical and Other Records, and all rules applicable to the specific service or item in OAR Ch 410 and Ch 309.

(d) Access to records, inclusive of medical charts and financial records does not require authorization or release from a member if the purpose is:
(A) To perform billing review activities;
(B) To perform utilization review activities;
(C) To review quality, quantity, and medical appropriateness of care, items, and services provided;
(D) To facilitate payment authorization and related services;
(E) To investigate a client's contested case hearing request;
(F) To facilitate investigation by the MFCU or DHHS; or
(G) Where review of records is necessary to the operation of the program.
(e) If a provider determines that a submitted claim or encounter is incorrect, the provider is obligated to submit, within 30 calendar days of the date on which the overpayment was identified, an Individual Adjustment Request and refund the amount of the overpayment, if any, consistent with the requirements of OAR 410-120-1280. When the provider determines that an overpayment has been made, the provider must notify and reimburse the Authority immediately, following the reimbursement procedures in OAR 410-120-1397.
(f) Upon written request from the Authority, MFCU, Oregon Secretary of State, the DHHS, law enforcement agency or their authorized representatives the provider must furnish, at the providers expense, requested documentation immediately or within the time-frame specified in the request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of the Authority, Department, MFCU, or DHHS may, together or separately, review and copy the original documentation in the provider's place of business.
(g) Payment may be denied or subject to recovery if a review or audit determines the care, service or item was not provided in accordance with Authority rules or does not meet the criteria for quality or medical appropriateness of the care, service or item or payment.
(h) PIAU will use the sampling methods and calculation of overpayment methodology outlined in OAR 410-120-1396. When the Authority determines that an overpayment has been made to a provider, the amount of overpayment is subject to recovery.
(i) Prior to identifying an overpayment, the Authority or designee may contact the provider for the purpose of providing preliminary information and requesting additional documentation. Provider must provide the requested documentation to Authority within the time frames requested, unless any good cause for an extension in OAR 410-120-1396 is shown.
(j) When an overpayment is identified, Authority will notify the provider in writing, as to the nature of the discrepancy, the method of computing the dollar amount of the overpayment, and any further action that the Authority may take in the matter.
(k) The provider may appeal an Authority notice of overpayment in the manner provided in OAR 410-120-1396.
(A) All Authority administrative review decisions are subject to procedures established in OAR 410-120-1396 and OAR 137-004-0080 to 137-004-0092 and judicial review under ORS 183.484 in the Circuit Court.
(B) The contested case hearing process is conducted in accordance with ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700 and OAR 410-120-1396.
(L) When overpayment is identified in an audit finding, the Authority may recover overpayments made to a provider by direct reimbursement, offset, civil action, or other actions authorized by law.
(m) Authority will suspend provider enrollment and any payments, all or in part, when a credible allegation of fraud exists pursuant to federal law under 42 CFR 455.23, whether presented to the Authority, DHS, DOJ MFCU, or law enforcement entity; unless there is a pending investigation and good cause exists to continue payment.
(n) In addition to any overpayment, Authority may impose sanctions on a provider in connection with the actions that resulted in the overpayment or pursue other remedies specific to contract(s) between the provider and Authority.
(4) Provider sanctions in OAR 410-120-1400 may result in suspension or termination of the provider enrollment and the provider's Division assigned provider number.
(5) Authority may communicate with and coordinate any program integrity actions with the MFCU, DHS, and other

federal and state oversight authorities.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-123-1060

RULE TITLE: Definition of Terms

NOTICE FILED DATE: 10/15/2020

RULE SUMMARY: OAR 410-123-1060 Definition of Terms sets forth the meaning of new and revised oral health program vocabulary. Terms used within the oral health program rules are defined to achieve clarity in the statement and purpose of the rule of Oregon law, regulation and oversight of Medicaid programs.

RULE TEXT:

(1) “Acute” has the meaning as provided in OAR 410-120-0000.
(2) “Ambulatory Surgical Center (ASC)” has the meaning as provided in OAR 410-120-0000.
(3) “Ancillary Service” has the meaning as provided in OAR 410-120-0000.
(4) “Anesthesia” refers to the Oregon Board of Dentistry administrative rules (OAR chapter 818, division 026).
(5) “Anesthesia Services” has the same meaning as OAR 410-120-0000 and means administration of anesthetic agents to cause loss of sensation to the body or body part.
(6) “By Report (BR)” has the meaning as provided in OAR 410-120-0000.
(7) “Current Dental Terminology (CDT)” means a listing of descriptive terms identifying dental procedure and nomenclature used by the American Dental Association.
(8) “Citizen/Alien-Waived Emergency Medical” has the meaning as provided in OAR 410-120-0000. The acronym “CAWEM” has the same meaning.
(9) “Co-Payments” means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See OAR 410-120-1230 Client Copayment.)
(10) “Covered Services” has the meaning as provided in OAR 410-120-0000.
(11) “COVID-19 Emergency” means the period: 1. Starting on the earliest of any COVID-19 public health emergency affecting the delivery of health care services and declared by the Secretary of HHS pursuant to 42 U.S.C. § 247d, by the Governor of Oregon, or by OHA; and 2. Ending on the latest of any COVID-19 public health emergency affecting the delivery of health care services and declared by the Secretary of HHS pursuant to 42 U.S.C. § 247d, by the Governor of Oregon, or by OHA. OHA will publish guidance on the CCO Contracts Website regarding the duration of the COVID-19 Emergency. This pertains to leniencies under HIPAA and delivery modalities provided in telehealth/teledentistry due to the COVID-19 Emergency. See OAR 410-120-1990.
(12) “Dental” means having to do with the teeth.
(13) “Dental Emergency Services” has the meaning as provided in OAR 410-120-0000.
(14) “Dental Hygienist” has the meaning as provided in OAR 410-120-0000.
(15) “Dental Hygienist with Expanded Practice Dental Hygiene Permit (EPDH)” has the meaning as provided in OAR 410-120-0000.
(16) “Dental Practitioner” means an individual licensed pursuant to state law to engage in the provision of dental services within the scope of the practitioner’s license and certification.
(17) “Dental Services” has the meaning as provided in OAR 410-120-0000, and means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist or denture services provided within the scope of practice as defined under state law by a denturist or Limited Access Permit (LAP).
(18) “Dental Services Documentation” means meeting 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 OAR chapter 410 division 123 (Dental rules).
(19) “Dental Emergency Condition” means a condition based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results. Dental Emergency Condition may include but is not limited to severe tooth pain, unusual swelling, or an avulsed tooth.

(20) “Dental Urgent Care” focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital emergency departments. These should be treated as minimally invasively as possible. Examples of Dental Urgent Care Conditions include: Severe dental pain from pulpal inflammation; Pericoronitis or third-molar pain; Surgical post-operative osteitis; Dry socket dressing changes; Abscess, or localized bacterial infection resulting in localized pain and swelling; Tooth fracture resulting in pain or causing soft tissue trauma; Dental trauma with avulsion/luxation; Dental treatment required prior to critical medical procedures; Final crown/bridge cementation if the temporary restoration is lost, broken or causing gingival irritation; Biopsy of abnormal tissue; Extensive dental caries or defective restorations causing pain, managed with interim restorative techniques when possible (silver diamine fluoride, glass ionomers); Suture removal; Denture adjustment on radiation/ oncology patients; Denture adjustments or repairs when function impeded; Replacing temporary filling on endo access openings in patients experiencing pain; Snipping or adjustment of an orthodontic wire or appliances piercing or ulcerating the oral mucosa.
(21) “Dentally Appropriate” as provided in OAR 410-120-0000, means health services, items, or dental supplies:
(a) Recommended by a licensed health provider practicing within the scope of their license;
(b) Safe, effective and appropriate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence;
(c) Not solely for the convenience or preference of an OHP client, member or a provider of the service, item or dental supply; and
(d) The most cost effective of the alternative levels or types of health services, items, or supplies that are covered services that can be safely and effectively provided to a client or member in the Division or MCE’s judgement.
(e) All Covered Services must be Dentally Necessary or Dentally Appropriate for the Member or Client, but not all Dentally Necessary or Dentally Appropriate services are Covered Services.
(22) “Dentist” has the meaning as provided in OAR 410-120-0000.
(23) “Denturist” has the meaning as provided in OAR 410-120-0000.
(24) “Distant Site” means the site where the dentist is being contacted for consultation by the originating site.
(25) “Division” has the meaning as provided in OAR 410-120-0000.
(26) “Emergency Medical Condition” has the same meaning as OAR 410-120-0000 and means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.
(27) “Emergency Services” has the meaning as provided in OAR 410-120-0000 and means health services from a qualified provider necessary to evaluate or stabilize an emergency dental or medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the patient’s condition is not likely to materially deteriorate from or during a client’s discharge from a facility or transfer to another facility.
(28) “Fee-for-Service Provider” has the meaning as provided in OAR 410-120-0000.
(29) “Hospital Dentistry” means dental services normally done in a dental office setting but due to specific client need (as detailed in OAR 410-123-1490) are provided in an ambulatory surgical center, inpatient or outpatient hospital setting under general anesthesia, or IV conscious sedation, if appropriate.
(30) “Managed Care Entity (MCE)” has the meaning as provided in OAR 410-141-3500.
(31) “Managed Care Organization (MCO)” has the meaning as provided in OAR 410-120-0000.
(32) “Medical Practitioner” means an individual licensed pursuant to state law to engage in the provision of medical services within the scope of the practitioner’s license and certification.
(33) “Medicament” means a substance or combination of substances intended to be pharmacologically active, specially prepared to be prescribed, dispensed, or administered to prevent or treat disease.
(34) “Originating Site” means the site where the patient is located, and dental care providers are working and performing services in conjunction with a dentist who is not at that site, all while using telehealth technology.

(35) “Physician” has the meaning as provided in OAR 410-120-0000.
(36) “Prepaid Ambulatory Health Plans” has the meaning provided in 42 CFR §438.2. The acronym “PAHP” has the same meaning.
(37) “Prepaid Health Plan” and “PHP” each has the meaning as provided in OAR 410-120-0000.
(38) “Primary Care Dentist (PCD)” as stated in OAR 410-120-0000, means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members.
(39) “Primary Care Provider (PCP)” as stated in OAR 410-120-0000, means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005.
(40) “Prior Authorization” has the meaning as provided in OAR 410-120-0000. The acronym “PA” has the same meaning.
(41) “Procedure Codes” means the procedure codes set forth in OAR chapter 410, division 123 that refer to Current Dental Terminology (CDT), unless otherwise noted. Codes listed in this rule and other documents incorporated in rule by reference are subject to change by the American Dental Association (ADA) without notification.
(42) “Provider” has the meaning as provided in OAR 410-120-0000.
(43) “Referral” as stated in OAR 410-120-0000, means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services.
(44) “Standard of Care” means what reasonable and prudent practitioners would do in the same or similar circumstances.
(45) “Teledentistry” means the modalities specified in OAR 410-123-1265, using electronic and telecommunications technologies, for the distance delivery of dental care services and clinical information designed to improve a patient’s health status and to enhance delivery of the health care services and clinical information.
(46) “Telehealth” means for the purposes of OAR 410-123-1265, OAR 410-120-1990 and as specified in ORS 679.543, a variety of methods using electronic and telecommunications technologies for the distance delivery of health care services, including dental care services and clinical information designed to improve a patient’s health status and to enhance delivery of the health care services and clinical information.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-123-1100

RULE TITLE: Services Reviewed by the Division of Medical Assistance Programs (Division)

NOTICE FILED DATE: 10/15/2020

RULE SUMMARY: Rule 410-123-1100 is being repealed and incorporated into rule 410-123-1000: Eligibility, Services Reviewed by the Division, Billing and the Dental Billing Invoice.

RULE TEXT:

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

(2) By Report Procedures:

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

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

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

(a) Before issuing PA;

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

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

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-123-1160

RULE TITLE: Prior Authorization

NOTICE FILED DATE: 10/15/2020

RULE SUMMARY: OAR 410-123-1160 requires oral health providers to follow Oregon Health Authority (OHA) prior authorization requirements before providing oral surgery, maxillofacial surgery, hospital dentistry or major oral health procedures on Medicaid clients. This rule does not require prior authorization of outpatient or inpatient services related to dental emergency conditions defined within the rule.

RULE TEXT:

(1) Health Services Division (Division) prior authorization (PA) requirements:

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

(A) Crowns (porcelain fused to metal);

(B) Crown repair;

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

(D) Complete dentures;

(E) Immediate dentures;

(F) Partial dentures;

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

(H) Fixed partial denture repairs;

(I) Skin graft; and

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

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

(c) Oral surgical services require PA when performed in an ambulatory surgical center (ASC) or an outpatient or inpatient hospital setting and related anesthesia. Refer to OAR 410-123-1260 (Oral Surgery Services), and the current Medical Surgical Services administrative rule OAR 410-130-0200 for information;

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

(2) The Division does not require PA for outpatient or inpatient services related to a "Dental Emergency Condition" which means determination based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results. Dental Emergency Condition may include but is not limited to severe tooth pain, unusual swelling, or an avulsed tooth. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(3) How to request PA:

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

(b) Documentation submitted when requesting authorization must support the medical justification for the service. The authorization request must contain:

(A) A cover sheet detailing relevant provider and recipient Medicaid numbers;

(B) Requested dates of service;

(C) HCPCS or Current Dental Terminology (CDT) Procedure code requested;

(D) Amount of service or units requested; and

(E) Any additional clinical information supporting medical justification for the services requested;

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

(A) When radiographs are required, they must be:

(i) Readable copies;
(ii) Mounted or loose;
(iii) In an envelope, stapled to the PA form;
(iv) Clearly labeled with the dentist's name and address and the client's name; and
(v) If digital x-ray, they must be of photo quality;
(B) Do not submit radiographs unless it is required by the Dental Services administrative rules or they are requested during the PA process.
(4) The Division will issue a decision on PA requests within 30 days of receipt of the request. The Division will provide PA for services when:
(a) The prognosis is favorable;
(b) The treatment is practical;
(c) The services are dentally appropriate; and
(d) A lesser-cost procedure would not achieve the same ultimate results.
(5) PA does not guarantee client eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on each date of service.
(6) For certain services and billings, the Division will seek a general practice consultant or an oral surgery consultant for professional review to determine if a PA will be approved. The Division will deny PA if the consultant decides that the clinical information furnished does not support the treatment of services.
(7) MCE PA requirements:
(a) For services other than hospital dentistry, contact the client’s Dental Care Organization (DCO) for PA requirements for individual services and/or supplies listed in the Dental Services administrative rules. DCOs may not have the same PA requirements for dental services as listed in this administrative rule;
(b) For hospital dentistry, refer to OAR 410-123-1490 for details regarding PA requirements.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065, 414.707

STATUTES/OTHER IMPLEMENTED: ORS 414.065, 414.707

AMEND: 410-123-1220

RULE TITLE: Coverage According to the Prioritized List of Health Services

NOTICE FILED DATE: 10/15/2020

RULE SUMMARY: This rule amendment incorporates by reference the “Covered and Non-Covered Dental Services” data base located at: https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-Covered-and-Non-Covered-Dental-Cod/5t6q-5tkx/data and dated January 1, 2021. The data base lists coverage of Current Dental Terminology (CDT) procedure codes according to the Oregon Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) and Medicaid health benefit packages.

RULE TEXT:

(1) This rule incorporates by reference the “Covered and Non-Covered Dental Services” data base located at: https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-Covered-and-Non-Covered-Dental-Cod/5t6q-5tkx/data and dated January 1, 2021.

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

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

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

(a) The Division administrative rules (chapter 410, division 123) do not reflect the most current Prioritized List changes until the rules are amended through the Division rule filing process;

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

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

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

(4) The Prioritized List does not include or fund the following general categories of dental services, and the Division does not cover them for any client. Several of these services are considered elective or “cosmetic” in nature (i.e., done for the sake of appearance):

(a) Desensitization;

(b) Implant and implant services;

(c) Mastique or veneer procedure;

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

(e) Overhang removal;

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

(g) Temporomandibular joint dysfunction treatment; and

(h) Tooth bleaching.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

REPEAL: 410-123-1240

RULE TITLE: The Dental Claim Invoice

NOTICE FILED DATE: 10/15/2020

RULE SUMMARY: Rule 410-123-1240 defined and clarified the dental claim invoice process, dental co-payments, and Electronic Data Interchange (EDI) claim submission rules for oral health providers.
This rule is being repealed in order to combine it with OAR 410-123-1000 as Eligibility, Services Reviewed by the Division, Billing and the Dental Billing Invoice.

RULE TEXT:
(1) Providers: Refer to the Dental Services Provider Guide for information regarding claims submissions and billing information.
(2) Providers billing dental services on paper must use the 2012 version of the American Dental Association (ADA) claim form.
(3) Submission of electronic claims directly or through an agent must comply with the Electronic Data Interchange (EDI) rules. OAR 943-120-0100 et seq.
(4) Specific information regarding Health Insurance Portability and Accountability Act (HIPAA) requirements can be found on the Division Web site.
(5) Providers will not include any client co-payments on the claim when billing for dental services.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-123-1260

RULE TITLE: OHP Dental Benefits

NOTICE FILED DATE: 10/15/2020

RULE SUMMARY: The language of OAR 410-123-1260 clarifies how the Oregon Health Plan (OHP) covers newly opened Current Dental Terminology (CDT) codes and restored benefits as of October 1, 2016. The rule references the "Covered and Non-Covered Dental Services" database dated January 1, 2021, which houses all CDT codes, OHP coverage or non-coverage statuses, Health Evidence Review Commission (HERC) prioritized list lines, guideline note references and benefit limitations for oral health program providers.
Oral health providers are referred to the Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, eligible clients, and related services.
In addition, clarifying language was added to the rule regarding the historical reference to "trauma" in the replacement of full and/or partial dentures. New language states: Full and partial dentures that the client owns may be replaced in cases of loss due to circumstances beyond the member's control or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster.
The bulk of benefit descriptions occur through a new dental benefit data base and incorporated in rule by reference - the "Covered and Non-Covered Dental Services" database dated January 1, 2021, is located on the Health Systems Division (Division) website at: https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-Covered-and-Non-Covered-Dental-Cod/5t6q-5tkx/data.

RULE TEXT:
(1) This administrative rule aligns with and reflects changes to the Prioritized List of Health Services and the American Dental Association's (ADA) Code on Dental Procedures and Nomenclature (CDT Codes), as well as a restoration of benefits resulting from legislative action in 2015. Effective January 1, 2017, the Health Evidence Review Commission (HERC) added and deleted oral health procedure codes. This rule provides information on how the Oregon Health Plan covers newly opened CDT codes and restored benefits as of October 1, 2016. Incorporated by reference the "Covered and Non-Covered Dental Services" database dated January 1, 2021, is located on the Health Systems Division (Division) website at: https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-Covered-and-Non-Covered-Dental-Cod/5t6q-5tkx/data. All CDT codes, OHP coverage or non-coverage statuses, prioritized list lines, guideline note references and benefit limitations are found in the above referenced database. Instructions for database use can be found in the Dental Services Provider Guide: https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx.
(2) GENERAL:
(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT):
(A) Refer to Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the EPSDT program, eligible clients, and related services. EPSDT dental services include but are not limited to:
(i) Dental screening services for eligible EPSDT individuals; and
(ii) Dental diagnosis and treatment that is indicated by screening at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.
(B) Providers shall provide EPSDT services for eligible Division clients according to the following documents:
(i) The Dental Services program administrative rules (OAR chapter 410, division 123), for dentally appropriate services funded on the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List); and
(ii) The "Oregon Health Plan (OHP) - Recommended Dental Periodicity Schedule," dated April 1, 2018, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document at: https://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Dental.aspx.
(b) Restorative, periodontal, and prosthetic treatments:
(A) Documentation shall be included in the client's charts to support the treatment. Treatments shall be consistent with the prevailing standard of care and may be limited as follows:

(i) When prognosis is unfavorable;
(ii) When treatment is impractical;
(iii) A lesser-cost procedure achieves the same ultimate result; or
(iv) The treatment has specific limitations outlined in this rule.
(B) Prosthetic treatment, including porcelain fused to metal crowns, are limited until rampant progression of caries is arrested and a period of adequate oral hygiene and periodontal stability is demonstrated; periodontal health needs to be stable and supportive of a prosthetic.
(c) Full and/or partial denture replacement: For indications and limitations of coverage and dental appropriateness, the Division may cover reasonable and necessary replacement of dentally appropriate, covered full and/or partial dentures, including those items purchased or in use before the client enrolled with the Division.
(A) Replacement of full and/or partial dentures because of loss due to circumstances beyond the member's control, accident or natural disaster/ Situations involving the provision of dentally appropriate items when:
(i) There is a change in the client's condition that warrants a new device;
(ii) The item is not repairable; and
(iii) There is coverage for the specific item as identified in chapter 410, division 123.
(iv) Full and partial dentures that the client owns may be replaced in cases of loss due to circumstances beyond the member's control or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster.
(B) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of full and/or partial dentures may not be covered. All other dental services are represented in the above referenced Dental Benefits Database.

STATUTORY/OTHER AUTHORITY: ORS 413.042, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065

AMEND: 410-123-1265

RULE TITLE: Teledentistry

NOTICE FILED DATE: 10/15/2020

RULE SUMMARY: The language in 410-123-1265 defines teledentistry as utilizing telehealth systems for oral care specifically through synchronous and asynchronous forms (i.e. live video and mobile communication devices). This rule clarifies general billing requirements and teledentistry billing requirements necessary for payment of oral health services performed within the dental health program's scope of practice.
The need for the current changes is to migrate the definitions previously within OAR 410-123-1265 to the Oregon Administrative General Rules – OAR 410-120 and to change the prior references to the Medical/Surgical rule OAR 410-130, re: Telehealth- to the Oregon Administrative General Rule – 410-120-1990 where the Telehealth rule resides, effective January 1, 2021.

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

(B) When those types and specific services are not specifically allowed in this rule per the Oregon Health Evidence Review Commission's Prioritized List of Health Services.
(b) The dentist may bill for teledentistry on the same type of claim form as other types of procedures unless in conflict with the Dental Services rules;
(c) All Dental Services rules, criteria, and limits apply to teledentistry services in the same manner as other services;
(d) As stated in ORS 679.543 and this rule, payment for dental services may not distinguish between services performed using teledentistry, real time, or store-and-forward and services performed in-person.
(5) Teledentistry billing requirements:
(a) The dentist who completes diagnosis and treatment planning and the oral evaluation also documents these services using the traditional CDT codes. This provider also reports the teledentistry event using D9995 or D9996 as appropriate. See the Dental Billing Instructions for details at: www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx;
(b) The originating site may bill a CDT code only if a separately identifiable service is performed within the scope of practice of the practitioner providing the service. The service must meet all criteria of the CDT code billed.
(6) An assessment-D0191 is a limited inspection performed to identify possible signs of oral or systemic disease, malformation or injury, and the potential need for referral for diagnosis and treatment. This code may be billed using the modality of teledentistry:
(a) When D0191 is reported in conjunction with an oral evaluation (D0120-D0180) using teledentistry, D0191 shall be disallowed even if done by a different provider;
(b) The assessment and evaluation may not be billed or covered by both the originating site dental care provider and a distant site dentist using the modality of teledentistry, even if due to store-and-forward review, if the dates of services are on different days.

STATUTORY/OTHER AUTHORITY: ORS 679.543, ORS 414.065

STATUTES/OTHER IMPLEMENTED: ORS 414.065