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

FILING CAPTION: FEE-FOR-SERVICE DENTAL/DENTURIST SERVICES

EFFECTIVE DATE: 01/01/2022

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RULES:
410-123-0010, 410-123-1000, 410-123-1025, 410-123-1060, 410-123-1160, 410-123-1200, 410-123-1220, 410-123-1230, 410-123-1250, 410-123-1260, 410-123-1262, 410-123-1265, 410-123-1490, 410-123-1510, 410-123-1540, 410-123-1600, 410-123-1620, 410-123-1660

ADOPT: 410-123-0010

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Add foreword for clarity on usage of fee-for-service dental rules and usage by managed care organizations that have no specific dental rules in place.

CHANGES TO RULE:

410-123-0010
Foreword
(1) The Oregon Health Plan offers Medicaid dental/denturist benefits on a fee-for-service (FFS) basis and through Managed Care Entities. These rules are Division rules designed to assist fee-for-service providers direction in the delivery of dental services and in the preparation of dental care claims.¶
(2) Managed Care Entities (MCE) provide dental/denturist services under an approved contract with the Authority. In accordance with 42 CFR 438.210, all Managed Care Entities are required to provide medical and dental services furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under FFS Medicaid.¶
(a) MCEs' must adhere to the Fee-for-Service Dental/Denturist Services rules in providing the minimum standard of care allowed per federal regulations and within the MCE's contract. MCEs may provide services above and beyond these rules, according to each contract agreement, State Plan, and 1115 Waiver.¶
(b) For clients enrolled in an MCE, refer to the MCE rules and contracts for services rendered above and beyond the minimum standard found within the Fee-for-Service Dental/Denturist Services rules or guides. The MCE has the authority to provide more services than those found in these rules, as long as the amount, duration and scope is no less than the amount, duration and scope for the same services provided in these rules.¶
(c) The Fee-for-Service Dental/Denturist rules do not list every policy, procedure, and criteria for services. All Division rules shall be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR 410 Division 120), and the Oregon Health Plan (OHP) Administrative Rules for Managed Care Entities (OAR 410 division 141).

Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1000

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity, and restoration of previous detail needed by OHA employees, dental organizations and CCOs for dental billing, coding, and claims audits.

CHANGES TO RULE:

410-123-1000
Eligibility, Services Reviewed by the Division, Billing and the Dental Billing Invoice
(1) Eligibility:¶
(a) Providers ~~are responsible for verification of client eligibility and must~~must verify client eligibility and benefit coverage of clients on each day of service, and shall do so before providing any service or billing t~~he~~o the:¶
(A) Oregon Health Authority~~,~~ (referred to as "Authority" throughout these rules);¶
(B) Health Systems Division (~~Division) or any Oregon Health Plan (OHP~~referred to as "Division" throughout these rules);¶
(C) Oregon Health Plan (referred to as "OHP" throughout these rules); or¶
(D) Managed Care Entit~~i~~y (~~MCE);¶~~
~~(b) The Division may not pay~~referred to as "MCE" throughout these rules).¶
(b) A client medical identification card does not guarantee eligibility on the date of service. The Division shall does not pay reimburse for services provided to an ineligible client, even if services were authorized before a client loses benefit coverage due to changes in income, household size, redetermination status, or any other factor. Refer to General Rules OAR 410-120-1140 (Verification of Eligibility) for details.¶
(2) Services Reviewed by the ~~Health Services Division (Division)~~Division:¶
(a) Services requiring ~~p~~Prior ~~a~~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 Pr~~ocedures:¶~~
~~(A) Request for payment for d~~icing:¶
(A) Most dental services are included in a standard fee schedule. However, some services are not included in the fee schedule because they are unique. Procedures for such services are "by report" meaning the provider shall submit a written report to justify the services;¶
(B) Dental services listed as "~~b~~By ~~r~~Report" (BR) ~~must~~shall be submitted with a ~~full description of the procedure, including~~n adequate definition or description of the nature, extent, and need for the procedure, the time, effort and necessary equipment medically necessary to provide the service, and any relevant operative or clinical history reports and/or radiographs. Payment for BR procedures will be approved in consultation with a Division dental consultant;¶
(~~B~~C) 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.~~for a list of procedure codes noted as BR. See OAR 410-123-1220.¶
(3) Billing:¶
(a) Providers are prohibited from billing or seeking to collect payment from an OHP member (or any financially responsible relative or representative of that individual) for Medicaid covered services outside of any cost-sharing, coinsurance or copay required by the plan. See 42 CFR 447.20 (a) for more detail;¶
(~~3~~b) ~~Billing:¶~~
~~(a) Providers must~~For non-covered services, a provider may bill a Medicaid patient when all of the following conditions are met:¶
(A) The provider has an established policy for billing all patients for services not covered by a third party. The charges may not only apply to Medicaid patients;¶
(B) The patient is advised prior to receiving a non-covered service that Medicaid will not pay for the service;¶
(C) the patient or patient's parent or legal guardian agrees to be personally responsible for the service;¶
(D) An Agreement to Pay (OHP 3165/3166) form or other form that contains all of the elements of the OHP 3165/3166 is signed and dated by the patient;¶
(E) The patient's Medicaid Identification Card may not be held by the provider as guarantee of payment by the patient;¶
(F) The estimated fee for the service does not change;¶
(G) The procedure or service is provided within 30 days of the patient's signature.¶
(c) Providers shall 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~~d) Providers ~~must~~shall 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 ~~d~~Documentation that supports the specific care, items, or services for which payment has been requested~~;~~.¶
(A) The Authority will only pay for services that are adequately documented~~.~~.¶
(B) Documentation ~~must~~shall 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~~shall 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~~shall keep clinical information on file for seven years, and financial records five years. Providers contracted with an MCE ~~must~~shall retain all clinical records for a minimum of ten (10) years after the date of services for which claims are made, as in 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~~shall be retained until all issues arising out of the action are resolved.¶
(~~c~~e) Third Party Resources: A ~~t~~Third ~~p~~Party ~~r~~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~~shall 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~~f) For Medicaid covered services, the provider ~~must~~shall 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 ~~d~~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~~shall include ~~d~~Documentation to support the appropriateness of the service and level of care rendered;¶
(i) The Division shall only reimburse for dental services that are ~~d~~Dentally ~~a~~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;¶
(L) Fabricated Prosthetics:¶
(A) If a dentist or denturist provides an eligible client with fabricated prosthetics that require the use of a dental laboratory, the date of the final impressions shall have occurred prior to the client's loss of eligibility;¶
(B) The dentist/denturist should use the date of final impression as the date of service only when criteria in (A) is met and the fabrication extends beyond the client's OHP eligibility;¶
(C) The date of delivery shall be within 45 days of the date of the final impression and the date of delivery shall also be indicated on the claim. All other services shall be billed using the date the service was provided.¶
(4) Billing Invoice:¶
(a) Providers~~: R~~ shall refer to the Dental Services Provider Guide for information regarding claims submissions and billing information~~.~~.¶
(b) Providers billing dental services on paper ~~must~~shall use the 2019 version of the American Dental Association (ADA) claim form~~.~~.¶
(c) Submission of electronic claims directly or through an agent ~~must~~shall 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~~shall 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~~shall be submitted after:¶
(a) Delivery of service; or¶
(b) Dispensing, shipment or mailing of the item.¶
(7) The provider ~~must~~shall 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~~shall 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 ~~d~~Documentation, the member's treatment or care plan, as applicable, and compliant with program specific rules. All ~~d~~Documentation ~~must~~shall be complete and signed by the rendering provider prior to submitting a claim the Authority or MCE for payment.¶
(c) If an ~~o~~Overpayment has been made by the Authority, the provider ~~is required to~~shall 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 ~~o~~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 ~~o~~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 ~~o~~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~~shall bill as instructed in the appropriate Authority program rules and ~~must~~shall 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~~shall 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~~shall follow national coding guidelines;¶
(c) When there is no appropriate descriptive procedure code to bill the Authority, the provider ~~must~~shall use the code for "unlisted services." A complete and accurate description of the specific care, item, or service ~~must~~shall 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~~shall 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

AMEND: 410-123-1025

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup

CHANGES TO RULE:

410-123-1025
Program Integrity and Provider Audits
(1) The Oregon Health Authority (Authority) uses several approaches to promote program integrity and preventing ~~f~~Fraud, waste and ~~a~~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~~shall comply with OAR 410-120-1510, OAR 461-195-0601 and the requirements therein for prompt reporting of ~~f~~Fraud, waste and ~~a~~Abuse in the Medicaid program:¶
(a) Providers ~~must~~shall report all suspected ~~f~~Fraud, waste and ~~a~~Abuse by a provider, including ~~f~~Fraud, waste or ~~a~~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~~shall report all suspected ~~f~~Fraud or ~~a~~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 ~~f~~Fraud, waste and ~~a~~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 ~~o~~Overpayments and uncover possible instances of ~~f~~Fraud, waste, and ~~a~~Abuse~~.~~;¶
(b) Providers ~~must~~shall 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~~shall 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 ~~o~~Overpayment was identified, an Individual Adjustment Request and refund the amount of the ~~o~~Overpayment, if any, consistent with the requirements of OAR 410-120-1280.

When the provider determines that an ~~o~~Overpayment has been made, the provider ~~must~~shall 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~~shall furnish, at the providers expense, requested ~~d~~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 ~~d~~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 ~~o~~Overpayment methodology outlined in OAR 410-120-1396. When the Authority determines that an ~~o~~Overpayment has been made to a provider, the amount of ~~o~~Overpayment is subject to recovery.~~:~~;¶
(i) Prior to identifying an ~~o~~Overpayment, the Authority or designee may contact the provider for the purpose of providing preliminary information and requesting additional ~~d~~Documentation. Provider ~~must~~shall 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 ~~o~~Overpayment is identified, the Authority will notify the provider in writing, as to the ~~nature of the~~ discrepancy, the method of computing the dollar amount of the ~~o~~Overpayment, and any further action that the Authority may take in the matter.~~:~~;¶
(k) The provider may appeal an Authority notice of ~~o~~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 ~~o~~Overpayment is identified in an audit finding, the Authority may recover ~~o~~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 ~~f~~Fraud exists pursuant to federal law under 42 CFR 455.23, whether presented to the Authority, ODHS, DOJ MFCU, or law enforcement entity; unless there is a pending investigation and good cause exists to continue payment.~~:~~;¶
(n) In addition to any ~~o~~Overpayment, Authority may impose sanctions on a provider in connection with the actions that resulted in the ~~o~~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

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity, addition of terms, and restoration of previous detail needed by OHA employees, dental organizations and CCOs for dental billing, coding, and claims audits.

CHANGES TO RULE:

410-123-1060
Definition of Terms ¶

(1) ~~"Acute"~~Abuse has the meaning as provided in OAR 410-120-0000.¶
(2) "A~~mbulatory Surgical Center (ASC)~~cute" has the meaning as provided in OAR 410-120-0000.¶
(3) "A~~ncillary Service~~mbulatory Surgical Center (ASC)" 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) "C~~o-Payments~~MS-416" 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 Cl~~annual EPSDT participation report required by Section 1902(a)(43)(D) of the Social Security Act, which assesses the Oregon Health Plan's effectiveness in providing screening and dental services for EPSDT eligible children according to the appropriate periodicity schedule. For the purpose of the measurement, "Dental" services refer to services provided by or under the supervision of a dentist. "Oral health" services refer to services provided by a licensed practitioner that is not a dentist. For example, a pediatrician that applies a fluoride varnish, or an independently practicing dental hygien~~t Copayment.)~~ist not under the supervision of a dentist.¶
(10) "Covered Services" has the meaning as provided in OAR 410-120-0000.¶
(11) "COVID-19 Emergency" means the period: ~~1.~~¶
(a) 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~~the Authority; and ~~2.~~¶
(b) 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 Con~~the Authority.¶
(12) "Dental" means conditions having to do with the teeth and supporting str~~a~~uct~~s 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~~ures.¶
(13) "Dental Care Organization" (DCO) means a managed care entity that contracts, on a capitated basis, with the Authority under ORS 414.654 or with a coordinated care organization, or both with the Authority and a coordinated care organization, to provide dental services to medical assistance recipients.¶
(1~~3~~4) "Dental Emergency Services" has the meaning as provided in OAR 410-120-0000. For the purpose of Division rules, Dental Emergency Services is synonymous with emergency dental care and emergency oral health care.¶
(14~~5~~) "Dental Hygienist" has the meaning as provided in OAR 410-120-0000.¶
(15~~6~~) "Dental Hygienist with Expanded Practice Dental Hygiene Permit (EPDH)" has the meaning as provided in OAR 410-120-0000.¶
(16~~7~~) "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~~8~~) "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~~Expanded Practice Permit (~~LA~~EPP).¶
(18~~9~~) "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 ~~d~~Documentation requirements as outlined in OAR chapter 410 division 123 (Dental rules).¶
(~~19~~20) "Dental Emergency Condition" means a ~~condition~~ny incident involving the teeth and gums which would require immediate treatment to stop ongoing tissue bleeding, alleviate severe and sudden pain or infection, treat unusual swelling of the face or gums, or to preserve an avulsed tooth:¶
(a) Emergency conditions are based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results~~. Dental Emergency Condition may include but is not~~;¶
(b) The treatment of an emergency dental condition is limited only to ~~se~~Covere ~~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 trea~~d Services. The Division recognizes that some non-Covered Services may meet the criteria of treatment for the emergency condition; however, this rule does not extend ~~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 localiz~~to those non-Covered Service.¶
(21) "Dental Therapist" has the meaning provided in ORS 679.010.¶
(22) "Dentally Appropriate" has the meaning as provided in OAR 410-120-0000.¶
(23) "Dentally Necessary" has the meaning provided ~~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); Sutur~~OAR 410-120-0000.¶
(24) "Dentist" has the meaning as provided in OAR 410-120-0000.¶
(25) "Denturist" has the meaning as provided in OAR 410-120-0000.¶
(26) "Distant Site" means the site where the dentist is being contacted for consultation by the originating site.¶
(27) "Documentation" means dental services documentation which meets the requirements of the Ore~~moval; Denture adjustment on radiation/ oncology patients; Denture adjustment~~gon Dental Practice Act statutes, administrative rules for ~~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 prac~~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).¶
(28) "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services" means the federally mandated comprehensive and preventati~~c~~ve ~~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 C~~child health program for individuals under the age of 21, under the Omnibus Budget Reconciliation Act of 1989 and Section 1905(r)(5) of the Social Security Act. Consistent with state and federal law and regulations, the OHP Dental Program ensures that all dentally necessary services and screenings are provided, either directly or through an Authority contracted MCE for EPSDT covered ~~S~~services.¶
(2~~2~~9) "~~Dentist~~Fee-for-Service Provider" has the meaning as provided in OAR 410-120-0000.¶
(2~~3~~0) "~~Denturist~~Fraud" has the meaning as provided in OAR 410-120-0000.¶
(24~~31~~) "~~Distant Site" means the site where the dentist is being contacted for consultation by the originating site~~Health Care Interpreter (HCI)" means an individual who has been approved and certified by the Authority under ORS 413.558 to accurately interpret oral statements and documents to a person with limited English proficiency or in sign language. Qualified Health Care Interpreter has the same meaning.¶

(325) "Health Systems 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, and is within the Authority. The Division is responsible for managing the Oregon Health Plan (OHP), which is Oregon's Medicaid program.¶
(33) "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.¶
(2734) "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 mayInterpreter Services" means services available to those with Limited English Proficiency (LEP) as described in Title VI of the Civil Rights Act of 1964; Section 1557 of the Affordable Care Act; and ORS 413.550 for Meaningful Language Access Interpreter services may also be neaccessary 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 facilityed for deaf or hard of hearing patients to ensure effective communication, as required by the Americans with Disabilities Act. The interpreter shall be a certified or qualified health care interpreter (HCI).¶
(2835) "Fee-for-Service ProviderManaged Care Entity (MCE)" has the meaning as provided in OAR 410-120-0000.¶
(29) "Hospital Dentistry" means dental services normally done in a dental office sett41-3500, and refers to any entity that enters into a contract to provide covered services in a managed care delivery system, including, but due to specific client need (as detailed in OAR 410-123-1490) are provided in an ambulatory surgical center, not limited to, managed care organizations (MCO), prepaid health plans (PHP), coordinpatient or outpatient hospital setting under general anesthesia, or IV conscious sedation, if appropriate.¶
(30) "Med care organizations (CCO), and dental care organizations (DCO). Federal managed Ccare Entity (MCE)" has the meaning as provided in OAR 410-141-3500.¶
(31) "Managed Care Organization (MCO)" has the meaning as provided in OAR 410-120-0000rules and managed care model benefits may vary, depending upon federal requirements for MCEs, MCE contract requirements, and metric measures required by MCEs.¶
(326) "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.¶
(337) "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.¶
(348) "Oral Health" means conditions of the lips, tongue, inner cheeks, soft and hard palate.¶
(39) "Oral Health Care" means services including, but not limited to, diagnostic, preventive, therapeutic, urgent, or emergency services provided by dental practitioners, dental specialists, dental hygienists, dental therapists, and trained primary care providers. In the dental field, oral health care and dental health care are used synonymously.¶
(40) "Oral Health Services" means services provided by a non-dentist (such as primary care physicians and nurse practitioners) and not under a dentist's supervision.¶
(41) "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.¶
(42) "Overpayment" has the meaning as provided in OAR 410-120-0000.¶
(435) "Physician" has the meaning as provided in OAR 410-120-0000.¶
(3644) "Prepaid Ambulatory Health Plans" has the meaning provided in 42 CFR 438.2. The acronym "PAHP" has the same meaning. ¶
(3745) "Prepaid Health Plan" and "PHP" each has the meaning as provided in OAR 410-120-0000.¶
(3846) "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.¶
(3947) "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.¶
(408) "Prior Authorization" has the meaning as provided in OAR 410-120-0000. The acronym "PA" has the same

meaning.¶
(41) "Prioritized List of Health Services" (The List) means the comprehensive list of health services, ranked by priority, from the most important to the least important. The Oregon Health Plan benefits are made from The List and determined by the Oregon Legislature.¶
(50) "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¶
(53) "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.¶
(56) "Urgent Dental Care" means the management of conditions that require prompt attention to relieve pain and/or risk of infection and to alleviate the burden on hospital emergency departments. These should be treated as minimally invasively as possible. Urgent dental care is distinguished from emergency dental care in that, urgent dental care requires prompt but not immediate treatment. Examples include dull toothache, mildly swollen gums, or small chips or cracks in teeth. Members shall be seen or treated for Urgent Dental care within two weeks. Urgent care treatment is limited to covered services.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1160

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity

CHANGES TO RULE:

410-123-1160
Prior Authorization
(1) Health Services Division (Division) prior authorization (PA) requirements~~:~~ ¶
~~(a)~~. For fee-for-service (FFS) dental clients, the following services require PA:~~-~~¶
(~~A~~a) Crowns (porcelain fused to metal/porcelain ceramic);~~-~~¶
(~~B~~b) Crown repair;~~-~~¶
(~~C~~c) Retreatment of previous root canal therapy - anterior;~~-~~¶
(~~D~~d) Complete dentures;~~-~~¶
(~~E~~e) Immediate dentures;~~-~~¶
(~~F~~f) Partial dentures;~~-~~¶
(~~G~~g) Prefabricated post and core in addition to fixed partial denture retainer;~~-~~¶
(~~H~~h) Fixed partial denture repairs;~~-~~¶
(~~I~~i) Skin graft;~~ and~~ ¶
(~~J~~j) Orthodontics (when covered pursuant to OAR 410-123-1260)~~;~~. ¶
(~~b~~k) Hospital dentistry always requires PA, regardless of the client's enrollment status. Refer to OAR 410-123-1490 for more information;~~-~~¶
(~~c~~L) 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~~m) Maxillofacial surgeries may require PA in some instances. Refer to the current Medical Surgical Services ~~administrative rule~~OAR 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~~shall document any appropriate clinical information that supports the need for the hospitalization. Refer to Line 54 of the Prioritized List of Health Services for funded emergency dental service codes.¶
(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~~shall support the medical justification for the service. The authorization request ~~must~~shall 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~~shall 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~~shall 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 ~~d~~Dentally ~~a~~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: 410-123-1200

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity

CHANGES TO RULE:

410-123-1200
Services Not ~~To Be Billed Separately~~ Eligible for Separate Reimbursement ¶

(1) Services ~~that are not to be billed separately may be included in the Current Dental Terminology (CDT) codebook and may not be listed as combined with another procedure; however,~~considered incidental, integral to the primary service rendered, part of another service, or included in routine post-op or follow-up care are not eligible for separate reimbursement. Participating providers may not balance bill members for these services. Services the~~y~~at are ~~considered to be either minimal, included in the examination, part of another service, or included in routine post-op or follow-up ca~~not to be billed separately may be included in the Current Dental Terminology (CDT) codebook and may not be listed as combined with another procedure.¶
(2) The following services ~~do~~are not ~~warrant an additional fee~~eligible for separate reimbursement:¶
(a) Alveolectomy/Alveoloplasty in conjunction with extractions;¶
(b) Cardiac and other monitoring;¶
(c) Caries risk assessment and ~~d~~Documentation;¶
(d) Curettage and root planing - per tooth is not eligible for separate reimbursement unless the service is significant and separately identifiable;¶
(e) Diagnostic casts;¶
(f) Dietary counseling;¶
(g) Direct pulp cap;¶
(h) Discing;¶
(i) Dressing change;¶
(j) Electrosurgery;¶
(k) Equilibration;¶
(~~l~~L) Gingival curettage - per tooth;¶
(m) Gingival irrigation;¶
(n) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth;¶
(o) Indirect pulp cap;¶
(p) Local anesthesia;¶
(q) Medicated pulp chambers;¶
(r) Occlusal adjustments;¶
(s) Occlusal analysis;¶
(t) Odontoplasty;¶
(u) Oral hygiene instruction;¶
(v) Periodontal charting, probing;¶
(w) Post removal;¶
(x) Polishing fillings;¶
(y) Post extraction treatment for alveolaritis (dry socket treatment) if done by the provider of the extraction;¶
(z) Pulp vitality tests;¶
(aa) Smooth broken tooth;¶
(bb) Special infection control procedures;¶
(cc) Surgical procedure for isolation of tooth with rubber dam;¶
(dd) Surgical splint;¶
(ee) Surgical stent; and¶
(ff) Suture removal.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1220

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity

CHANGES TO RULE:

410-123-1220
Coverage According to the Prioritized List of Health Services ¶

(1) This rule, effective January 01, 2022, 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 D~~January 01, 2022 Oregon Health Evidence Review Commission (HERC) Prioritized List of Health Services (The List), funded through line 472 and including all line items, diagnostic and treatment codes, guideline notes, statements of intent, coding specifications and annotations. All material included therein are incorporated in and made part of this rule by this reference, including interim modifications reported as required under ORS 414.690(7) and (8).¶
(a) The Prioritized List of Health Services includes line items consisting of diagnosis and treatment codes that pair together with specific conditions on the same line. Each line has a description of both a condition(s) and treatment for the condition(s). Services on lines 1-472 are covered for OHP Clients, with some dental ~~S~~services~~" data base lists coverage of Current Dental Terminology (CDT) procedure cod~~ subject to exclusion for adults age 21 and over. Coverage of these services is included in the benefit package when providers follow The List's code pairing, Guideline Notes, ~~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;~~nnotations and statements of intent. The Benefit Package also covers additional services described in this rule.¶
(b) Diagnostic and Preventive Service codes. Approved CDT codes for preventive dental services are included on the funded portion of The Prioritized List of Health Services, and limitations specified in related Guideline Notes. Dental and Oral Health Providers are subject to utilizing The List for procedure and diagnosis code pairing and funding of preventive and diagnostic services. Preventive services include prophylaxis, sealants, fluoride varnish application, caries arresting medicaments, and vaccinations. Diagnostic services include examinations, imaging, oral evaluations, and testing. All diagnosis and preventive service codes are subject to The List Guidelines Notes and limitations found in this rule.¶
(c) Ancillary service codes. Covered ancillary codes are subject to applicable Ancillary Guidelines on The List. Approved ancillary codes are listed in this rule at OAR 410-123-1620. ¶
(~~b~~d) Th~~is document is subject to change if there are funding changes to the~~e List shall be used in conjunction with applicable OHP provisions found in federal and state laws, the State Plan and Oregon's 1115(a) Waiver for coverage of services such as, but not limited to:¶
(A) Services on unfunded lines for children ages from birth through 1;¶
(B) Services provided for a condition appearing in the funded region of The List in conjunction with federal requirements for Early and Perio~~ritized List.~~dic Screening, Diagnosis and Treatment (EPSDT) and Oregon's 1115(a) Waiver;¶
(2) Regardless of The List placement, dental and oral health services shall be dentally necessary and clinically appropriate for each individual client served.¶
(~~2~~3) Changes to services funded on ~~t~~The ~~Prioritized~~ List are effective on the date of ~~t~~The ~~Prioritized~~ List change:¶
(a) The Division administrative rules (chapter 410, division 123) do not reflect the most current Prioritized List of Health Services changes until the rules are amended through the Division rule filing process;¶
(b) For the most current Prioritized List of Health Services, refer to the HERC website at https://www.oregon.gov/oha/~~herc~~HPA/DSI-HERC/Pages/Prioritized-List.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~~4) Refer to ~~OAR 410-123-1260 and it's referenced data base~~The List of Services and OAR 410-123-1260 for information about limitations on procedures funded, according to ~~t~~The ~~Prioritized~~ List. Examples of limitations include frequency and client's age.¶
(~~4) The Prioritized~~5)The 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~~;~~ (See Prioritized List Guideline Notes 123 and 169);¶

(c) Mastique or veneer procedure;¶
(d) Orthodontia (except ~~when it is treatment~~ for cleft palate, cleft lip, or cleft palate with cleft lip treatments, or to correct cranial facial abnormalities);¶
(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

AMEND: 410-123-1230

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity

CHANGES TO RULE:

410-123-1230
Buying-Up ¶

(1) Buying-up as defined in OAR 410-120-0000 is prohibited.¶
(2) Providers are not permitted to bill and accept payment from the Division o~~f Medical Assistance Programs (Division) or a managed care plan~~r an MCE for a covered service when:¶
(a) A non-covered service has been provided; and¶
(b) Additional payment is sought or accepted from the client.¶
(3) If a client wants to purchase a non-covered service or item, the client ~~must be~~shall sign and date a provider-completed Agreement to Pay Form before becoming responsible for full payment. A payment from the Division or the managed care plan for a covered service cannot be credited toward the non-covered service and then an additional client payment sought to obtain, for example, a gold crown (not covered) instead of the stainless steel crown (covered).
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1250

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity

CHANGES TO RULE:

410-123-1250
Dental HbA1c Testing
(1) Hemoglobin A1c is a measure of the amount of glucose attached to red blood cells and directly relates to average blood glucose levels.¶
(a) Dental HbA1c testing for at risk patients is within the scope of dental practice for Oregon licensed oral health providers. Although not presumed to be a standard of care, testing serves as a resource for dentists which supports identification of those patients with HbA1c levels that are above the normal range, and that can affect periodontal status, wound healing, infection control and other conditions of the oral environment.;¶
(b) The OHAAuthority and the Oregon Board of Dentistry have determined that licensed oral health providers shall refer patients, once identified with HbA1c levels above normal range, to their primary care provider for evaluation, diagnosis and treatment.¶
(2) Licensed oral health providers shall share the HbA1c test results with the patient's primary care provider to promote care collaboration and avoid duplication. If the results of the test indicate risk, the dental provider shall establish bi-directional communication with the patient's primary care provider to communicate test results and initiate a referral for evaluation, diagnosis and treatment, collaborate on care, and communicate progress of treatment and oral health status.¶
(3) Licensed oral health providers shall comply with OAR 410-130-0680, as it pertains to blood testing, and 42 CFR 493 and OAR 333-024-0005 through 333-024-0055, as it pertains to Clinical Laboratory Improvement Amendments (CLIA) for laboratory enrollment requirements and processes, as identified at https://www.oregon.gov/oha/PH/LaboratoryServices/ClinicalLaboratoryRegulation/Pages/index.aspx.¶
(4) Oregon licensed oral health providers and facilities shall apply for a Certificate of Waiver (CMS 1600), available on the CLIA webpage, in order to perform any HbA1c testing. Waived tests are not exempt from CLIA certification, as stated on the website and the CMS 1600.¶
(5) In determining the need for dental HbA1c testing, dentists shall take into account patient risk factors based on appropriate, consensus-based guidelines and the dentist's best clinical judgement.¶
(6) Release of Information:¶
(a) Providers shall ensure a patient release of information is on file in the patient's record in order to provide the HbA1c test and to make the needed referral, referenced in subsection (2) of this rule, to the patient's primary care provider for further evaluation, diagnosis and treatment.;¶
(b) Should the patient not have a PCP, providers shall:¶
(A) Inform the patient of the test findings and direct toward resources containing more information and encourage to become a physician's patient of record for their other health needs; and¶
(B) Document actions in the patient's record, with follow-up at the next visit.¶
(c) Referrals mustshall be tracked and documented in the patient's record.;¶
(d) Patients may decline testing. Providers shall provide sufficient information regarding the purpose of the test and the procedure, including its relevance to both oral and general health, so that an informed patient decision can be made.¶
(7) Frequency of testing requirements and limitations:¶
(a) Providers shall perform HbA1c testing on the same patient no more frequently than annually unless the dentist determines it medically/dentally necessary to test more frequently due to unexplained progression of periodontal disease, delayed wound healing or recurrent oral candida infection. HbA1c should not be tested more frequently than every 3 months.;¶
(b) The Division shall reimburse providers using D0411, and in alignment with OAR 410-130-0680, once per day, regardless of the frequency performed for drawing/collecting blood via capillary puncture.¶
(8) Coding and reimbursement:¶
(a) Dental HbA1c testing is completed under CDT code D0411, using modifier QW, and submitted on a CMS 1500 professional claim form, instructions found at https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Medical-Surgical.aspx - Professional Billing Instructions. The D0411 billing code allows for separate specific billing and data environments for HbA1c testing done in the dental environment and avoids crossover into the medical billing or data streams.;¶
(b) The rate for reimbursement is found at https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx, effective January 1, 2020.

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

AMEND: 410-123-1260

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity, addition of guidance on EPSDT, and restoration of previous detail needed by OHA employees, dental organizations and CCOs for dental billing, coding, and claims audits.

CHANGES TO RULE:

410-123-1260
OHP Dental Benefits ¶

(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, 2~~in relation to the American Dental Association (ADA) diagnosis and treatment pairs that are above the funding line and consistent with treatment guidelines on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List of Health Services or List) found in OAR 410-141-3830 and not otherwise excluded under OAR 410-141-3825.¶
(2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):¶
(a) Medicaid-eligible participants from birth up through the day before their twenty-first birthday are eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. This benefit covers age-appropriate screening visits and medically necessary Medicaid-covered services to treat identified physical, dental, developmental, and mental health conditions;¶
(b) Oregon's Medicaid and CHIP State Plans lists services covered under the OHP benefit package;¶
(c) For children over age one, Oregon's Medicaid 1115 Demonstration Waiver covers all EPSDT medically necessary services that are included on the prioritized list;¶
(d) Dental providers shall deliver EPSDT Dental Health Care screening visits and services at age-appropriate intervals following 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;¶
(e) Dental providers shall establish the delivery of routine preventive care services to children referred from primary care providers who deliver Oral Health Care screenings and fluoride varnish services in the medical setting;¶
(f) Prior Authorization and Referral requirements are imposed on medical and dental service Providers under EPSDT. Such requirements are designed as tools for determining a service, treatment or other measure meets the standards in subsection 2(c) of this section. The Authority determines which treatment to cover based upon the Provider's recommendations, current clinical guidance, and availability of equally effective alternative treatments;¶
(g) Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B which were in effect as of January 01, 1998. EPSDT services shall be medically or dentally necessary, and include, but are not limited to:¶
(A) Dental preventive screening services;¶
(B) Dental diagnosis and Dentally Necessary 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.¶
(3) Oral Health Services in Primary Care Settings - D0190 or D0191:¶
(a) Reimbursement is available to certified FFS and MCE Primary Care Providers who deliver an oral evaluation, family oral health education, and topical application of fluoride varnish during EPSDT well-child periodicity scheduled visits:(A) Assessment from a medical provider does not count toward the maximum number of services allowed by a dental provider;¶
(B) Medical providers may not delegate oral assessment to other staff members;¶
(C) The FQHC assessment encounter rate is inclusive of this service when performed during the medical or dental visit.¶
(b) For reimbursement in a medical setting, the performing provider shall meet all of the following criteria:¶
(A) Be a Physician (MD or DO), an advance practice nurse, or a licensed Physician assistant;¶
(B) Hold a certificate of completion from one of the following training programs within the previous three years:¶
(i) Smiles for Life;¶

(ii) or First Tooth.¶
(C) Perform oral health assessment/exam of infants and toddlers under six years of age during medical periodicity or inter-periodicity well-child exam. CDT Code D0190 or D0191 shall be used for the Oral Health Care assessment portion of the well-child visit and may be used up to once per year for medical providers;¶
(D) Perform a caries risk assessment for children under six years of age using a standardized tool either:¶
(i) The First Tooth Tool developed by the Oregon Oral Health Coalition, or¶
(ii) a tool endorsed by the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics.¶
(E) Make referral to a Dentist for FFS members or to the CCO member's assigned dental plan in order to establish a dental home with a primary care dentist. Preferably during the visit when an infant's first tooth erupts, commonly around six months of age. If patient has an established primary care dentist, refer the patient to their dental home for dental care;¶
(F) Provide anticipatory guidance and counseling with the client's caregiver on good oral hygiene practices and nutrition;¶
(G) Document in the medical chart risk assessment findings and service components provided.¶
(c) Topical fluoride treatment - D1206 or 99188:¶
(A) May be applied during any well-child visit for children under 19 years of age;¶
(B) If a medical provider delegates this procedure to a staff member, the staff member shall be trained on the application of fluoride varnish;¶
(C) Limited to two treatments yearly for children with low risk of tooth decay;¶
(D) Limited to four treatments yearly for children with high risk of tooth decay. Provider shall document visible decay and risk in patient chart;¶
(E) Fluoride treatment may be performed and billed during a separate well-child or preventative care visit from oral assessment;¶
(F) Use CDT code D1206 or CPT code 99188 and the appropriate ICD-10 fluoride administration code in the professional claim format as directed by the First Tooth or Smiles for Life program guide.¶
(G) CDT code D0190 is limited to use for mass screenings of children or non-dental professionals during EPSDT well-child and preventative care visits.¶
(d) Referrals:¶
(A) If, during the screening process (periodic or inter-periodic), a dental, medical, substance abuse, or medical condition is discovered, the client shall be referred to an appropriate provider for further diagnosis and/or treatment;¶
(B) The screening provider shall explain the need for the Referral to the client, client's parent, or guardian;¶
(C) If the client, client's parent, or guardian agrees to the referral, assistance in finding an appropriate provider and making an appointment should be offered;¶
(D) The child's FFS provider or the MCE program will also make available care coordination as needed.¶
(4) DIAGNOSTIC SERVICES (D0100 - D0999):¶
(a) Clinical Oral evaluations (Exams):¶
(A) For children under 19 years of age:¶
(i) The Division shall reimburse exams (billed as CDT codes D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations:¶
(I) D0150: once every 12 months when performed by the same practitioner;¶
(II) D0150: twice every 12 months only when performed by different practitioners;¶
(III) D0180: once every 12 months.¶
(ii) The Division shall reimburse D0160 only once every 12 months when performed by the same practitioner.¶
(B) For adults 19 years of age and older, the Division shall reimburse exams (billed as CDT codes D0120, D0150, D0160, or D0180) once every 12 months;¶
(C) For problem focused exams (urgent or emergent problems), the Division shall reimburse D0140 for the initial exam. The Division shall reimburse D0170 for related problem-focused follow-up exams. Providers shall not bill D0140 and D0170 for routine dental visits;¶
(D) The Division only covers oral exams performed by Medical Practitioners when the Medical Practitioner is an oral surgeon. The surgeon may hold a dual degree, but shall bill as an oral surgeon;¶
(E) As the American Dental Association's Current Dental Terminology (CDT) codebook specifies, the evaluation, diagnosis, and treatment planning components of the exam are the responsibility of the Dentist. The Division may not reimburse dental exams when performed by a Dental Hygienist (with or without an expanded practice permit).¶
(b) Assessment of a patient (D0191):¶
(A) When performed by a Dental Practitioner, the Division shall reimburse:¶
(i) If performed by a Dentist outside of a dental office;¶

(ii) If performed by a Dental Hygienist with an expanded practice dental hygiene permit, or a licensed dental therapist;¶
(iii) Only if an exam (D0120-D0180) is not performed on the same date of service. Assessment of a Patient (D0191) is included as part of an exam (D0120-D0180);¶
(iv) For children under 19 years of age, a maximum of twice every 12 months; and¶
(v) For adults age 19 and older, a maximum of once every 12 months.¶
(B) An assessment does not take the place of the need for oral evaluations/exams.¶
(c) Diagnostic imaging:¶
(A) The Division shall reimburse for routine imaging once every 12 months;¶
(B) The Division shall reimburse bitewing radiographs for routine screening once every 12 months;¶
(i) D0240, D0250, D0251, ~~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~~D0273, D0274, D0277, D0321, D0322, D0701 - D0709 reimbursed once ever 12 months for all clients;¶
(ii) D0210, D0330 reimbursed once every five years, unless D0210 has been billed within the five-year period.¶
(C) The Division shall reimburse a maximum of six images for any one emergency;¶
(D) For clients under age six, images may be billed separately every 12 months as follows:¶
(i) D0220 - once;¶
(ii) D0230 - a maximum of five times;¶
(iii) D0270 - a maximum of twice, or D0272 once.¶
(E) The Division shall reimburse for panoramic radiographic image or intra-oral complete series once every five years, but both cannot be done within the five-year period;¶
(F) Clients shall be a minimum of six years old for billing intra-oral complete series. The minimum standards for reimbursement of intra-oral complete series are:¶
(i) For clients age six through 11 - a minimum of ten periapicals and two bitewings for a total of 12 films;¶
(ii) For clients ages 12 and older - a minimum of ten periapicals and four bitewings for a total of 14 films.¶
(G) If fees for multiple single radiographs exceed the allowable reimbursement for a intraoral-complete series (full mouth), the Division shall reimburse for the complete series;¶
(H) Additional films may be covered if dentally or medically appropriate, e.g., fractures (refer to OAR 410-123-1060 and 410-120-0000);¶
(I) If the Division determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area may be denied;¶
(J) The exception to these limitations is if the client is new to the office or clinic and the office or clinic is unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting Documentation outlining the provider's attempts to receive previous records shall be included in the client's records;¶
(K) Digital radiographs, if printed, shall be on photo paper to assure sufficient quality of images.¶
(5) PREVENTIVE SERVICES (D1000-D1999):¶
(a) Dental prophylaxis:¶
(A) For children under 19 years of age - Limited to twice per 12 months;¶
(B) For adults 19 years of age and older - Limited to once per 12 months;¶
(C) Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily Oral Health Care.¶
(b) Topical fluoride treatment:¶
(A) For adults 19 years of age and older - Limited to once every 12 months;¶
(B) For children under 19 years of age - Limited to twice every 12 months;¶
(C) Additional topical fluoride treatments may be available, up to a total of four treatments per client within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for clients who:¶
(i) Have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;¶
(ii) Are pregnant;¶
(iii) Have physical disabilities and cannot perform adequate, daily Oral Health Care;¶
(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily

Oral Health Care; or¶
(v) Are under seven years old with high-risk oral health factors, such as poor oral hygiene, deep pits, and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.¶
(D) Fluoride limits include any combination of fluoride varnish or other topical fluoride.¶
(c) Sealants:¶
(A) Are covered only for children under 16 years of age;¶
(B) The Division limits coverage to:¶
(i) Permanent molars; and¶
(ii) Only one sealant treatment per molar every five years, except for visible evidence of clinical failure.¶
(d) Tobacco cessation:¶
(A) For services provided during a dental visit, bill as a dental service using CDT code D1320 when the following 5 step counseling is provided:¶
(i) ASK: Identify the patient's tobacco-use status at each visit and record information in the chart;¶
(ii) ADVISE: Using a strong personalized message, advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and seek help; and¶
(iii) ASSESS: If the tobacco user is willing to make a quit attempt, refer patient to external resources or internal counseling and intervention protocol.¶
(iv) ASSIST: If dental provider chooses to assist, provide counseling and pharmacotherapy to help patient quit tobacco.¶
(v) ARRANGE: Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date.¶
(B) The Division allows a maximum of ten services within a three-month period.¶
(e) Space maintenance (passive appliances):¶
(A) The Division shall cover fixed and removable space maintainers only for clients under 19 years of age;¶
(B) The Division may not reimburse for replacement of lost or damaged removable space maintainers.¶
(f) Interim caries arresting Medicament application (D1354/D1355):¶
(A) When used to represent silver diamine fluoride (SDF) applications for the treatment (rather than prevention) of caries, is limited to:¶
(i) Two applications per year;¶
(ii) Requires that the tooth or teeth numbers be included on the claim;¶
(iii) Shall be covered with topical application of fluoride when performed on the same date of service when treating a carious lesion;¶
(iv) Shall be covered with an interim therapeutic restoration (D2941) or a permanent restoration and (D1354/D1355) on the same tooth, when Dentally Appropriate.¶
(g) Interim caries arresting Medicament application (D1354) is also included on The List to arrest or reverse noncavitated carious lesions. See The List Guideline Note 91 for more detail.¶
(6) RESTORATIVE SERVICES (D2000-D2999):¶
(a) Amalgam and resin-based composite restorations, direct:¶
(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;¶
(B) The Division reimburses posterior composite restorations at the same rate as amalgam restorations;¶
(C) The Division limits payment for replacement of posterior composite restorations to once every five years;¶
(D) The Division limits payment of covered restorations to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) CDT codebook for definitions of restorative procedures;¶
(E) Providers shall combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces);¶
(F) The Division may not reimburse for an amalgam or composite restoration and a crown on the same tooth;¶
(G) Interim therapeutic restoration on primary dentition is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration;¶
(H) Reattachment of tooth fragment is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment;¶
(I) The Division reimburses for a surface not more than once in each treatment episode regardless of the number or combination of restorations;¶
(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration.¶
(b) Indirect crowns and related services:¶
(A) General payment policies:¶
(i) The fee for the crown includes payment for preparation of the gingival tissue;¶

(ii) The Division shall cover crowns only when:¶
(I) There is significant loss of clinical crown and no other restoration will restore function; and¶
(II) The crown-to-root ratio is 50:50 or better, and the tooth is restorable without other surgical procedures.¶
(iii) The Division shall cover core buildup only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50 percent of the tooth structure shall be remaining for coverage of the core buildup;¶
(iv) Reimbursement of retention pins is per tooth, not per pin.¶
(B) The Division shall not cover the following services:¶
(i) Endodontic therapy alone (with or without a post);¶
(ii) Aesthetics (cosmetics);¶
(iii) Crowns in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason.¶
(C) Prefabricated stainless steel crowns are allowed only for anterior primary teeth and posterior permanent or primary teeth;¶
(D) The Division shall cover the following only for clients under 21 years of age or who are pregnant:¶
(i) Prefabricated resin crowns are allowed only for anterior teeth, permanent or primary;¶
(ii) Prefabricated stainless-steel crowns with resin window are allowed only for anterior teeth, permanent or primary;¶
(iii) Prefabricated post and core in addition to crowns;¶
(iv) Permanent crowns (resin-based composite - D2710 and D2712, porcelain fused to metal (PFM) - D2751 and D2752), and porcelain ceramic - D2740 as follows:¶
(I) Limited to teeth numbers 6-11, 22, and 27 only, if Dentally Appropriate;¶
(II) Limited to four in a seven-year period. This limitation includes any replacement crowns allowed.¶
(III) Only for clients at least 16 years of age; and¶
(IV) Rampant caries are arrested, and the client demonstrates a period of oral hygiene before prosthetics are proposed.¶
(v) Porcelain fused to metal, and porcelain ceramic crowns shall also meet the following additional criteria:¶
(I) The Dental Practitioner has attempted all other Dentally Appropriate restoration options and documented failure of those options;¶
(II) Written Documentation in the client's chart indicates that PFM is the only restoration option that will restore function;¶
(III) The Dental Practitioner submits radiographs to the Division for review. History, ~~D~~diagnosis, and ~~T~~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~~plan may be requested. (See OAR 410-123-1100 Services Reviewed by the Division);¶
(IV) The client has documented stable periodontal status with pocket depths within 1-3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeters and over, Documentation shall be maintained in the client's chart of the Dentist's findings supporting stability and why the increased pocket depths will not adversely affect expected long-term prognosis;¶
(V) The crown has a favorable long-term prognosis; and¶
(VI) If the tooth to be crowned is a clasp/abutment tooth in partial denture, both prognosis for the crown itself and the tooth's contribution to partial denture shall have favorable expected long-term prognosis.¶
(E) Crown replacement:¶
(i) Permanent crown replacement limited to once every seven years;¶
(ii) All other crown replacement limited to once every five years; and¶
(iii) The Division may make exceptions to crown replacement limitations due to Acute trauma, based on the following factors:¶
(I) Extent of crown damage;¶
(II) Extent of damage to other teeth or crowns;¶
(III) Extent of impaired mastication;¶
(IV) Tooth is restorable without other surgical procedures; and¶
(V) If loss of tooth would result in coverage of removable prosthetic.¶
(F) Crown repair is limited to only anterior teeth.¶
(7) ENDODONTIC SERVICES (D3000-D3999):¶
(a) Endodontic therapy:¶
(A) Pulpal therapy on primary teeth is covered only for clients under 21 years of age;¶
(B) For permanent teeth:¶
(i) Anterior and bicuspid endodontic therapy is covered for all OHP Plus clients; and¶
(ii) Molar endodontic therapy:¶
(I) For clients through age 20, is covered only for first and second molars; and¶
(II) For clients age 21 and older who are pregnant, is covered only for first molars.¶
(C) The Division covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures.¶
(b) Endodontic retreatment and apicoectomy:¶
(A) The Division does not cover retreatment of a previous root canal or apicoectomy for bicuspid or molars;¶
(B) The Division limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:¶
(i) Crown-to-root ratio is 50:50 or better;¶
(ii) The tooth is restorable without other surgical procedures; or¶
(iii) If loss of tooth would result in the need for removable prosthodontics.¶
(C) Retrograde filling is covered only when done in conjunction with a covered apicoectomy of an anterior tooth.¶
(c) The Division does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service or if the same practitioner or Dental Practitioner in the same group practice completed the procedure;¶
(d) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;¶
(e) Apexification/recalcification procedures:¶
(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;¶
(B) Apexification/recalcification procedures are covered only for clients under 21 years of age or who are pregnant.¶
(8) PERIODONTIC SERVICES (D4000-D9999):¶
(a) Surgical periodontal services:¶
(A) Gingivectomy/Gingivoplasty - limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia; and¶

(B) Includes six months routine postoperative care;¶
(C) The Division shall consider gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) as part of the restoration and will not provide a separate reimbursement for this procedure.¶
(b) Non-surgical periodontal services:¶
(A) Periodontal scaling and root planing:¶
(i) Allowed once every two years;¶
(ii) A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;¶
(iii) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets of 5 mm or greater:¶
(I) D4341 is allowed for quadrants with at least four or more teeth with pockets of 5 mm or greater. Single implants may now be covered by counting the implant as an additional tooth when billing D4341. The maximum number per quadrant and pocket depth requirements still apply;¶
(II) D4342 is allowed for quadrants with at least two teeth with pocket depths of 5 mm or greater. Single implants may now be covered by counting the implant as an additional tooth when billing D4342. The maximum number per quadrant and pocket depth requirements still apply.¶
(iv) Prior Authorization for more frequent scaling and root planing may be requested when:¶
(I) Medically/Dentally Necessary due to periodontal disease as defined above is found during pregnancy; and¶
(II) Client's medical record is submitted that supports the need for increased scaling and root planing.¶
(B) Full mouth debridement allowed only once every two years.¶
(C) Scaling in the presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation, allowed only once every two years.¶
(c) Periodontal maintenance allowed once every six months:¶
(A) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;¶
(B) Prior Authorization for more frequent periodontal maintenance may be requested when:¶
(i) Medically/Dentally Necessary, such as due to presence of periodontal disease during pregnancy; and¶
(ii) Client's medical record is submitted that supports the need for increased periodontal maintenance (chart notes, pocket depths and radiographs).¶
(d) Records shall clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;¶
(e) The Division may not reimburse for procedures identified by the following codes if performed on the same date of service:¶
(A) D1110 (Prophylaxis - adult);¶
(B) D1120 (Prophylaxis - child);¶
(C) D4210 (Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant);¶
(D) D4211 (Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant);¶
(E) D4341 (Periodontal scaling and root planning - four or more teeth per quadrant);¶
(F) D4342 (Periodontal scaling and root planning - one to three teeth per quadrant);¶
(G) D4346 (Scaling in presence of generalized moderate to severe inflammation, full mouth after oral evaluation);¶
(H) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and¶
(I) D4910 (Periodontal maintenance).¶
(9) PROSTHODONTICS, REMOVABLE (D5000-D5899):¶
(a) Clients age 16 years and older are eligible for removable resin base partial dentures and full dentures;¶
(b) See OAR 410-123-1000 for detail regarding billing fabricated prosthetics;¶
(c) The fee for the partial and full dentures includes payment for adjustments during the six-month period following delivery to clients;¶
(d) Resin partial dentures:¶
(A) The Division may not approve resin partial dentures if stainless steel crowns are used as abutments;¶
(B) For clients through age 20, the client shall have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;¶
(C) For clients age 21 and older, the client shall have one or more missing anterior teeth or six or more missing posterior teeth per arch with Documentation by the provider of resulting space causing serious impairment to mastication. Third molars are not a consideration when counting missing teeth;¶
(D) The Dental Practitioner shall note the teeth to be replaced and teeth to be clasped when requesting Prior Authorization (PA).¶

(e) Replacement of removable partial or full dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:¶
(A) For clients at least 16 years of age, the Division shall replace:¶
(i) Full dentures once every ten years, only if Dentally Appropriate;¶
(ii) Partial dentures once every five years, only if Dentally Appropriate.¶
(B) The five- and ten-year limitations apply to the client regardless of the client's OHP or Dental Care Organization (DCO)/Coordinated Care Organization (CCO) enrollment status at the time the client's last denture or partial was received. For example: A client receives a partial on February 1, 2020 and becomes a FFS OHP client in 2023. The client is not eligible for a replacement partial until February 1, 2025. The client gets a replacement partial on February 3, 2025 while FFS and a year later enrolls in a DCO or CCO. The client would not be eligible for another partial until February 3, 2030, regardless of DCO, CCO, 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, natural disaster, or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant replacement.¶
(f) The Division limits reimbursement of adjustments and repairs of dentures that are needed beyond six months after delivery of the denture as follows for clients 21 years of age and older:¶
(A) A maximum of four times per year for:¶
(i) Adjustments to dentures, per arch. Full and partial (D5410 - D5422);¶
(ii) Replace missing or broken teeth - complete denture, each tooth (D5520);¶
(iii) Replace broken tooth on a partial denture - each tooth (D5640);¶
(iv) Add tooth to existing partial denture (D5650).¶
(B) A maximum of two times per year for:¶
(i) Repair broken complete denture base (D5511, D5512);¶
(ii) Repair resin partial denture base (D5611, D5612);¶
(iii) Repair cast partial framework (D5621, D5622);¶
(iv) Repair or replace broken retentive/clasping materials - per tooth (D5630);¶
(v) Add clasp to existing partial denture - per tooth (D5660).¶
(g) Replace all teeth and acrylic on cast metal framework (D5670, D5671):¶
(A) Is covered for clients age 16 and older a maximum of once every ten (10) years, per arch;¶
(B) Ten years or more shall have passed since the original partial denture was delivered;¶
(C) Is considered replacement of the partial so a new partial denture may not be reimbursed for another ten years; and¶
(D) Requires Prior Authorization as it is considered a replacement partial denture.¶
(h) Denture rebase procedures:¶
(A) The Division shall cover rebases only if a reline may not adequately solve the problem;¶
(B) For clients through age 20, the Division limits payment for rebase to once every three years;¶
(C) For clients age 21 and older:¶
(i) There shall be Documentation of a current reline that has been done and failed; and¶
(ii) The Division limits payment for rebase to once every five years.¶
(D) The Division may make exceptions to this limitation in cases of Acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing;¶
(i) Denture reline procedures:¶
(A) For clients through age 20, the Division limits payment for reline of complete or partial dentures to once every three years;¶
(B) For clients age 21 and older, the Division limits payment for reline of complete or partial dentures to once every five years;¶
(C) The Division may make exceptions to this limitation under the same conditions warranting replacement;¶
(D) Laboratory relines:¶
(i) Are not payable prior to six months after placement of an immediate denture;¶
(ii) For clients through age 20, are limited to once every three years;¶
(iii) For clients age 21 and older, are limited to once every five years.¶
(j) Interim partial dentures (also referred to as "flippers"):¶
(A) Are allowed if the client has one or more anterior teeth missing; and¶

(B) The Division shall reimburse for replacement of interim partial dentures once every five years but only when Dentally Appropriate.¶
(k) Tissue conditioning:¶
(A) Is allowed once per denture unit in conjunction with immediate dentures; and¶
(B) Is allowed once prior to new prosthetic placement.¶
(10) MAXILLOFACIAL PROSTHETIC SERVICES (D5900-D5999):¶
(a) Fluoride gel carrier is limited to those patients whose severity of oral disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The Dental Practitioner shall document failure of those options prior to use of the fluoride gel carrier;¶
(b) All other maxillofacial prosthetics (D5900-D5999) are medical services. Refer to the "Covered and Non-Covered Dental Services" document and OAR 410-123-1220:¶
(A) Bill for medical maxillofacial prosthetics using the professional (CMS1500, DMAP 505 or 837P) claim format;¶
(B) For clients receiving services through a CCO, PHP, or MCE bill medical maxillofacial prosthetics to the CCO, PHP, or MCE;¶
(C) For clients receiving medical services through FFS, bill the Division.¶
(11) ORAL & MAXILLOFACIAL SURGERY (D7000-D7999):¶
(a) Billing Procedures:¶
(A) Bill on a dental claim form using CDT codes for procedures that are directly related to the teeth and the structures directly supporting teeth;¶
(B) The Medical/Surgical Program is responsible for all oral health procedures performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, roof of mouth). Such procedures shall be billed using ICD-10, HCPCS and CPT billing codes using the professional (CMS1500, DMAP 505 or 837P) claim format;¶
(C) D7285, D7286, D7287, D7288 diagnosis codes are reimbursable for all members;¶
(D) D7990 ancillary code is reimbursable for all members;¶
(E) All ancillary and diagnosis codes must be dentally necessary.¶
(12) ORTHODONTICS (D8000-D8999):¶
(a) The Division covers orthodontia services and extractions to treat craniofacial malocclusions, anomalies, cleft lip or cleft palate with cleft lip when all of the following conditions are met:¶
(A) Using condition-treatment pair coding for craniofacial anomalies from the Prioritized List of Health Services;¶
(B) Following all corresponding Prioritized List Guideline Notes for treatment and care found on the Prioritized List treatment line;¶
(C) When treatment began prior to age 21, or surgical corrections for covered conditions were not completed prior to age 21;¶
(D) Significant malocclusion is expected to result in difficulty with mastification, speech, or other oral functions; and¶
(E) The Authority approves the request for fee-for-service coverage.¶
(b) PA is required for orthodontia exams and records;¶
(c) Documentation in the client's record shall include diagnosis, length, and type of treatment;¶
(d) Payment for appliance therapy includes the appliance and all follow-up visits;¶
(e) Orthodontists evaluate orthodontia treatment for cleft palate, cleft lip, or cleft palate with cleft lip, cranial facial abnormalities, and dental-facial impairments as two phases. Stage one is generally the use of an activator (palatal expander), and stage two is generally the placement of fixed appliances (banding). The Division shall reimburse each phase separately;¶
(f) The Division shall pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist shall refund to the Division any unused amount of payment after applying the following formula: Total payment minus $300.00 (for banding) multiplied by the percentage of treatment remaining;¶
(g) The Division shall use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;¶
(h) As long as the orthodontist continues treatment, the Division may not require a refund even though the client may become ineligible for medical assistance sometime during the treatment period;¶
(i) Code:¶
(A) D8660 - PA required (reimbursement for required orthodontia records is included);¶
(B) Codes D8010-D8690 - PA required.¶
(13) ADJUNCTIVE GENERAL AND OTHER SERVICES (D9000-D9999):¶
(a) Fixed partial denture sectioning is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly

treatment;¶
(b) Anesthesia:¶
(A) Only use general Anesthesia or IV sedation for those clients with concurrent needs: age; physical, medical or mental status; or degree of difficulty of the procedure;¶
(B) The Division reimburses providers with a current permit to administer general Anesthesia or IV sedation as follows:¶
(i) D9223 or D9243: For each 15-minute period, up to two and a half hours on the same day of service in a dental office setting, and up to three and a half hours on the same day of service in a hospital setting;¶
(ii) Each 15-minute period represents a quantity of one. Enter this number in the quantity column.¶
(C) The Division reimburses administration of Nitrous Oxide per date of service, not by time;¶
(D) Non-intravenous conscious sedation:¶
(i) Limited to clients under 13 years of age;¶
(ii) Limited to four times per year;¶
(iii) Includes payment for monitoring and Nitrous Oxide; and¶
(iv) Requires use of multiple agents to receive payment.¶
(E) Upon request, providers shall submit a copy of their permit to administer Anesthesia, analgesia, and sedation to the Division;¶
(F) For the purpose of Title XIX and Title XXI, the Division limits payment for code D9630 to those oral medications used during a procedure and is not intended for "take home" medication.¶
(c) The Division limits reimbursement of house/extended care facility call only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience;¶
(d) Oral devices/appliances (E0485, E0486):¶
(A) These may be placed or fabricated by a Dentist or oral surgeon but are considered a medical service);¶
(B) Bill the Division, CCO, or the PHP, or MCE for these codes using the professional claim format.¶
(C) CDT code D9947 shall be billed on a dental claim form. See HERC Guideline Notes 27 and 36 for limitations.¶
(D) Adjustments for oral sleep apnea appliances (D9948) are considered normal follow-up care within the first 90 days after provision of the device, and is included as a bundled rate with D9947.¶
(E) Oral sleep apnea repairs (D9949) are covered when necessary to make item serviceable. If the expense for repairs exceeds the estimated expense of purchasing another item, no payment shall be made for the excess.¶
(F) Oral sleep apnea appliances (D9947) are replaceable at the end of their five year reasonable useful lifetime.¶
(14) Restorative, Periodontal, and Prosthetic Treatment Limitations:¶
(a) Documentation shall be included in the client's charts to support the treatment;¶
(b) Treatments shall be consistent with the prevailing standard of care and may be limited as follows:¶
(A) When prognosis is unfavorable;¶
(B) When treatment is impractical;¶
(C) A lesser cost procedure achieves the same ultimate result; or¶
(D) The treatment has specific limitations outlined in this rule.¶
(c) Prosthetic treatment, including porcelain fused to metal crowns and porcelain/ceramic crowns are limited until rampant caries is arrested and a period of adequate oral hygiene and periodontal stability is demonstrated. Periodontal health needs to be stable and supportive of a prosthetic;¶
(d) 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;¶
(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.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1262

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity

CHANGES TO RULE:

410-123-1262
Dental Administration of Vaccines
(1) Dental administration of vaccines shall be carried out in compliance with Oregon Board of Dentistry OARs 818-012-000
Medical/Surgical OAR 410-130-0255 and Vaccines for Children (VFC) - OHA Division 46, OARs 333-046-0110 through 33
(2) ~~For the purpose of this rule, the following definitions apply:¶~~
~~(a) "Model Standing Orders" means prewritten orders and specific instructions for administration and frequency of a given~~
~~clearly defined circumstances. ¶~~
~~(b) "Vaccines for Children" (VFC) means a federal program that provides vaccine serums at no cost to providers for clients a~~
~~(3) The Health Services Division (Division) covers immunizations as recommended by the Advisory Committee on Immuniz~~
~~by the Oregon Immunization Program. The approved ACIP recommendations are found in Guideline Note 106 of the Healt~~
~~Prioritized List of Health Services as referenced in OAR 410-141-0520, www.oregon.gov/OHA/HPA/DSI-HERC (click "Cur~~
~~(4) Providers shall follow the (ACIP) guidelines for immunization schedules. Exceptions include: ¶~~
~~(a) On a case-by-case basis, provider may use clinical judgment in accordance with accepted medical practice to provide im~~
~~and; ¶~~
~~(b) On a case-by-case basis, provider may modify immunization schedule in compliance with the laws of the State of Oregon~~
~~and non-medical exemptions for immunizations.¶~~
~~(5)~~ Requirements for vaccine administration:¶
(a) The dentist shall have completed a course of training approved by the Oregon Board of Dentistry;¶
(b) Vaccines shall be administered in accordance with the Model Standing Orders approved by the ~~OHA~~Authority; and ¶
(c) The dentist shall not delegate administration of vaccines to another person.¶
(~~6~~3) Procedures for vaccine administration.¶
(a) Dentists shall:¶
(A) Follow ~~OHA~~Authority approved Model Standing Orders for immunization administration and treatment of severe adve
administration. ~~OHA~~Authority Model Standing orders are located at:
https://www.oregon.gov/oha/PH/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Pages/pr
Administration);¶
(B) Maintain written policies and procedures for handling and disposal of used or contaminated equipment and supplies;¶
(C) If providing state or federal vaccines, report the vaccine eligibility code~~,~~ as specified by the ~~OHA~~Authority, to the ALERT
https://www.oregon.gov/oha/PH/PreventionWellness/VaccinesImmunization/alert/Pages/EnrollNewClinic.aspx;¶
(D) As administrator of the vaccine, report to the ~~OHA~~Authority the information in section 6(a)(A), (B) and (C) of this rule as
ALERT Immunization System within fourteen (14) days of administration;¶
(E) Report adverse events, as required by the Vaccine Adverse Events Reporting System (VAERS) to the Oregon Board of D
days;¶
(F) Within ten (10) days to the primary care provider identified by the patient; and¶
(G) If the patient does not have a PCP, providers shall:¶
(i) Provide the patient with a copy of vaccination administration ~~d~~Documentation;¶
(ii) Direct toward resources containing more information;¶
(iii) Encourage to become a physician's patient of record for their other health needs; and ¶
(iv) Document actions in the patient's record.¶
(b) Dentists or designated staff shall:¶
(A) Provide Vaccine Information Statements (VIS) to the patient or legal representative with each dose of vaccine covered b
(B) Document that the patient or legal representative has read, or has had read to them, the information provided and that
the administration of the vaccine. The VIS provided ~~must~~shall be the most current version.~~;~~¶
(C) Document the patient record:¶
(i) Date;¶
(ii) Site of administration;¶
(iii) Brand name or NDC number or other acceptable standardized vaccine code set;¶
(iv) Dose, manufacturer, lot # (number), and expiration date of vaccine;¶
(v) Name and identifiable initials of administering dentist;¶
(vi) Address of office where vaccine was administered, unless automatically embedded in electronic report provided to the
System;¶
(vii) Date of publication of the VIS; and ¶

~~(viii)~~ Date the VIS was provided.¶
(~~7~~4) Billing: Vaccines are billed using a common procedural terminology (CPT) codes on a Professional claim form (CMS 150
Instructions and the Medical-Surgical Services Provider Guide located at: https://www.oregon.gov/OHA/HSD/OHP/Page/
(a) Adults: Billing providers shall use standard professional claim form billing procedures for adults and for any vaccine that
(b) Children: VFC vaccines are administered only to children and adolescents through age eighteen (18) who meet VFC eligi
age group and for conditions covered by the VFC program ~~must~~shall be obtained through the VFC program. The Division w
administration or purchase of privately purchased vaccines if the vaccine could have been obtained through the VFC progra
program or to enroll as a VFC provider, contact the Public Health Immunization Program. The Oregon VFC program websit
https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/IMMUNIZATIONPROVIDERRE
(~~8~~5) The Division reimburses only for the administration, not the serum, of vaccines available for free through the VFC Prog
Immunization Program State-Supplied Vaccine Billing Codes table for a list of vaccines provided through the VFC Program.
(~~9~~6) To receive reimbursement for vaccine administration, VFC program providers ~~must~~shall bill the Division:¶
(a) With the appropriate vaccine common procedural terminology (CPT) code included; and¶
(b) Including the appropriate modifier: SL.¶
(~~10~~7) Fee-for-service providers may bill the Division directly for vaccines provided to clients. Providers may bill the plans di
plan enrollment, for the administration of VFC vaccines if the client is enrolled in an MCE. Medicaid and CHIP are not consi
administration of VFC vaccines.¶
~~(11) Effective 1/1/2013 the Regional Maximum amount is $21.96. For all fee for service providers, the Division reimburses~~
~~the administration of VFC vaccines.~~
Statutory/Other Authority: ORS 679.543, 414.065, HB 2220 (2019 Regular Session)
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1265

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Minor language cleanup

CHANGES TO RULE:

410-123-1265
Teledentistry
(1) Teledentistry can take multiple forms, both synchronous and asynchronous, including but not limited to:¶
(a) Live video, a two-way interaction between a 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~~shall be licensed to practice dentistry within the State of Oregon or within the contiguous area of Oregon and ~~must~~shall 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) of this rule;¶
(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 ~~d~~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 ~~d~~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~~shall 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

AMEND: 410-123-1490

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Minor language cleanup, rule clarity

CHANGES TO RULE:

410-123-1490
Hospital Dentistry
(1) The purpose of hospital dentistry is to provide safe, efficient dental care when providing routine (non-emergency) dental services for ~~Division of Medical Assistance Programs~~ (Division) clients who present special challenges that require the use of general anesthesia or IV conscious sedation services in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting. Refer to OAR 410-123-1060 for definitions.¶
(2) Division reimbursement for hospital dentistry is limited to covered services and may be prorated if non-covered dental services are performed during the same hospital visit:¶
(a) See OAR 410-123-1060 for a definition of Division hospital dentistry services;¶
(b) Refer to OAR 410-123-1220~~and the "Covered and Non-Covered Dental Services" document.~~.¶
(3) Hospital dentistry is intended for the following Division clients:¶
(a) Children (18 or younger) who:¶
(A) Through age ~~3 --~~three (3): Have extensive dental needs;¶
(B) 4Four (4) years of age or older~~--~~: Have unsuccessfully attempted treatment in the office setting with some type of sedation or nitrous oxide;¶
(C) Have acute situational anxiety, fearfulness, extreme uncooperative behavior, uncommunicative such as a client with developmental or mental disability, a client that is pre-verbal or extreme age where dental needs are deemed sufficiently important that dental care cannot be deferred;¶
(D) Need the use of general anesthesia (or IV conscious sedation) to protect the developing psyche;¶
(E) Have sustained extensive orofacial or dental trauma;¶
(F) Have physical, mental or medically compromising conditions; or¶
(G) Have a developmental disability or other severe cognitive impairment and one or more of the following characteristics that prevent routine dental care in an office setting:¶
(i) Acute situational anxiety and extreme uncooperative behavior;¶
(ii) A physically compromising condition~~;~~.¶
(b) Adults (19 or older) who:¶
(A) Have a developmental disability or other severe cognitive impairment, and one or more of the following characteristics that prevent routine dental care in an office setting:¶
(i) Acute situational anxiety and extreme uncooperative behavior;¶
(ii) A physically compromising condition~~;~~.¶
(B) Have sustained extensive orofacial or dental trauma; or¶
(C) Are medically fragile, with a medical or physical condition which requires monitoring during dental procedures (i.e. coronary disease, asthma, or chronic obstructive pulmonary disease (COPD), heart failure, serious blood or bleeding disorder, or unstable diabetes or hypertension), have complex medical needs, contractures or other significant medical conditions potentially making the dental office setting unsafe for the client.¶
(4) Hospital dentistry is not intended for:¶
(a) Client convenience. Refer to OAR 410-120-1200;¶
(b) A healthy, cooperative client with minimal dental needs; or¶
(c) Medical contraindication to general anesthesia or IV conscious sedation.¶
(5) Required ~~d~~Documentation: The following information ~~must~~shall be included in the client's dental record:¶
(a) Informed consent: ~~c~~Client, parental or guardian written consent ~~must~~shall be obtained prior to the use of general anesthesia or IV conscious sedation;¶
(b) Justification for the use of general anesthesia or IV conscious sedation~~.~~: The decision to use general anesthesia or IV conscious sedation ~~must~~shall take into consideration:¶
(A) Alternative behavior management modalities;¶
(B) Client's dental needs;¶
(C) Quality of dental care;¶
(D) Quantity of dental care;¶
(E) Client's emotional development;¶
(F) Client's physical considerations~~;~~.¶
(c) If treatment in an office setting is not possible, ~~d~~Documentation in the client's dental record ~~must~~shall explain why, in the estimation of the dentist, the client will not be responsive to office treatment;¶

(d) The Division, ~~Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP)~~or MCE may require additional ~~d~~Documentation when reviewing requests for prior authorization (PA) of hospital dentistry services. See OAR 410-123-1160 and section (6) of this rule for additional information;~~¶~~
(e) If the dentist did not proceed with a previous hospital dentistry plan approved by the Division for the same client, the Division will also require clinical ~~d~~Documentation explaining why the dentist did not complete the previous treatment plan.~~¶~~
(6) Hospital dentistry always requires prior authorization (PA) for the medical services provided by the facility:~~¶~~
(a) If a client is enrolled in a ~~CCO or PHP and a Dental Care Organization (DCO):~~ n MCE:¶
(A) The dentist is responsible for:~~¶~~
(i) Contacting the ~~CCO or PHP~~MCE for PA requirements and arrangements; and~~¶~~
(ii) Submitting ~~d~~Documentation to ~~both the CCO or PHP and DCO;~~ all MCEs associated with the client record.¶
(B) The CCO or PHP and DCO should review the ~~d~~Documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan involvement and monitoring;~~¶~~
(C) The total response time should not exceed 14 calendar days from the date of submission of all required ~~d~~Documentation for routine dental care and should follow urgent/emergent dental care timelines;~~¶~~
(D) The CCO or PHP is responsible for payment of all facility and anesthesia services. The DCO is responsible for payment of all dental professional services~~;~~.¶
(b) If a client is enrolled in a Physician Care Organization (PCO) and a D~~ental Care Organization (DCO):~~ CO:¶
(A) The PCO is responsible for payment of all facility and anesthesia services provided in an outpatient hospital setting or an ASC. The Division is responsible for payment of all facility and anesthesia services provided in an inpatient hospital setting. The DCO is responsible for payment of all dental professional services;~~¶~~
(B) The dentist is responsible for:~~¶~~
(i) Contacting the PCO, if services are to be provided in an outpatient setting or an ASC, for PA requirements and arrangements; or~~¶~~
(ii) Contacting the Division, if services are to be provided in an inpatient setting; and~~¶~~
(iii) Submitting ~~d~~Documentation to both the PCO (or the Division) and the DCO;~~¶~~
(~~B~~C) The PCO or the Division and the DCO should review the ~~d~~Documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan involvement and monitoring;~~¶~~
(~~C~~D) The total response time should not exceed 14 calendar days from the date of submission of all required ~~d~~Documentation for routine dental care and should follow urgent/emergent dental care timelines~~;~~.¶
(~~b~~c) If a client is fee-for-service (FFS) for medical services and enrolled in a DCO:~~¶~~
(A) The dentist is responsible for faxing ~~d~~Documentation and a completed American Dental Association (ADA) form to the Division. Refer to the Dental Services Provider Guide;~~¶~~
(B) If the client is assigned to a Primary Care Manager (PCM) through FFS medical, the client ~~must~~shall have a referral from the PCM prior to any hospital service being approved by the Division;~~¶~~
(C) The Division is responsible for payment of facility and anesthesia services. The DCO is responsible for payment of all dental professional services;~~¶~~
(D) The Division will issue a decision on PA requests within 30 days of receipt of the request~~;~~.¶
(~~c~~d) If a client is enrolled in an ~~CCO or PHP~~MCE and is FFS dental:~~¶~~
(A) The dentist is responsible for contacting the ~~CCO or PHP~~MCE to obtain the PA and arrange for the hospital dentistry;~~¶~~
(B) The dentist is responsible for submitting required ~~d~~Documentation to the ~~CCO or PHP;~~ ¶
~~(C) The CCO or PHP~~MCE;¶
(C) The MCE is responsible for all facility and anesthesia services. The Division is responsible for payment of all dental professional services~~;~~.¶
(~~d~~e) If a client is FFS for both medical and dental:~~¶~~
(A) The dentist is responsible for faxing ~~d~~Documentation and a completed ADA form to the Division. Refer to the Dental Services Provider Guide;~~¶~~
(B) The Division is responsible for payment of all facility, anesthesia services and dental professional charges.
Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.707
Statutes/Other Implemented: ORS 414.065, 414.707

AMEND: 410-123-1510

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity

CHANGES TO RULE:

410-123-1510
Additional Dental Care ~~Access Standard~~Benefits for Pregnant ~~Women~~ Individuals ¶

(1) This rule sets forth the access standards for dental care for pregnant ~~women~~individuals who receive Oregon Health Plan (OHP) benefits through the fee-for-service (FFS) delivery system.¶
(2) Pregnant clients ~~must~~shall be seen, treated~~, or referred to~~ in person or via teledentistry for an OHP-covered service within the following time frames:¶
(a) For emergency dental care: within 24 hours;¶
(b) For urgent dental care: ~~one to~~within two weeks~~ or as indicated in the initial screening in accordance with OAR 410-123-1060;~~.¶
(c) For routine dental care: ~~an average of~~within four weeks, unless there is a documented special clinical reason that would make access longer than four weeks appropriate;¶
(d) For initial dental screening or examination: four weeks.¶
(3) Additional Dental Services are available to pregnant individuals if authorized as medically/Dentally Necessary due to the pregnancy. Additional services include:¶
(a) Additional prophylaxis, fluoride and periodontal services;¶
(b) Permanent crowns and resin-based composite crowns for anterior teeth;¶
(c) Prefabricated post and core;¶
(d) Root canals on first molars;¶
(e) Apexification/recalcification, pulpal regeneration;¶
(f) Alveoplasty not in conjunction with extractions.¶
(4) Nothing in this rule obligates a pregnant ~~woman~~individual who receives dental care through the ~~fee-for-service~~FFS delivery system to accept an offered appointment.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1540

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity

CHANGES TO RULE:

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

(1) CAWEM clients who are not pregnant (benefit package identifier CWM) have a limited benefit package. Dental coverage is limited to dental services provided in an emergency department hospital setting. Refer to OAR 410-120-1210~~(4)(e)~~.¶
(2) CAWEM clients who are pregnant (benefit package identifier CWX) receive the OHP Plus dental benefit package as described in OAR 410-123-1260.¶
(3) All CAWEM clients are exempt from enrollment in a Dental Care Organization (DCO) or Coordinated Care Organization (CCO). Providers ~~must~~shall bill the Division directly for any allowable services provided.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

REPEAL: 410-123-1600

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Repeal of this entire section

CHANGES TO RULE:

~~410-123-1600~~
~~Managed Care Organizations~~
~~(1) The Division contracts with Managed Care Organizations (MCO) and Primary Care Managers (PCM) to provide medical services for clients under the Division (Title XIX and Title XXI services): ¶~~
~~(a) MCOs for dental services are called Dental Care Organizations (DCO). See General Rules OAR 410-120-0250 - Managed Care Organizations for definitions and responsibilities of MCOs;¶~~
~~(b) See General Rules OAR 410-120-1210(4) - Medical Assistance Programs and Delivery Systems for a description of how clients receive services through MCOs and PCMs.¶~~
~~(2) The Division prepays DCOs to cover dental services, including the professional component of any services provided in an Ambulatory Surgical Center (ASC) or an outpatient or inpatient hospital setting for hospital dentistry. See OAR 410-123-1490 for more information about hospital dentistry.¶~~
~~(3) The Division will not pay for services covered by a MCO; reimbursement is a matter between the MCO and the provider. ¶~~
~~(4) For clients enrolled in a DCO, it is the responsibility of the dental provider to coordinate all dental services with the client's DCO prior to providing services.~~
~~Statutory/Other Authority: ORS 409.050, 414.065, ORS 414.725~~
~~Statutes/Other Implemented: ORS 414.725~~

AMEND: 410-123-1620

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Language cleanup, rule clarity

CHANGES TO RULE:

410-123-1620
Procedure and Diagnosis Codes ¶

(1) The Division requires providers to use the standardized code sets adopted by the Health Insurance Portability and Accountability Act (HIPAA) and the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers ~~must~~shall accurately code claims according to the national standards in effect for the date the service(s) was provided.¶
(2) Procedure codes:¶
(a) For dental services, and procedures that are directly related to the teeth and the structures supporting the teeth, use Current Dental Terminology (CDT) codes as maintained and distributed by the American Dental Association. Contact the American Dental Association (ADA) to obtain a current copy of the CDT reference manual. ~~Current Dental Terminology (including procedure codes, definitions (descriptors) and other data) is copyrighted by the ADA. 2012 American Dental Association. All rights reserved. Applicable Federal Acquisition Regulation Clauses/Department of Defense Federal Acquisition Regulation Supplement (FARS/DFARS) apply;¶~~
~~(b) For physician services and other health care services, use Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes¶~~
(b) For physician provided oral health services performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, cheek, roof of mouth), use Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. Such procedures are covered under the Division's medical surgical program found in Oregon Administrative Rule (OAR) 410-130-0000.¶
(3) Diagnosis codes:¶
(a) International Classification of Diseases 10th Clinical Modification (ICD-10-CM) diagnosis codes are not required for dental services submitted on an ADA claim form;¶
(b) When O~~regon Administrative Rule (OAR)~~AR 410-123-1260 requires services to be billed on a professional claim form, ICD-10-CM diagnosis codes are required. Refer to the Medical-Surgical administrative rules for additional information, OAR 410 division 130.¶
(4) Ancillary codes:¶
(a) Ancillary codes for hospitalization, medication and deep sedation are provided for conditions appearing above the funding line of the Prioritized List of Health Services, and subject to The List's ancillary guideline notes when applicable. Ancillary codes must be dentally or medically appropriate and part of the care for a funded condition on The List. Some ancillary codes are not eligible for separate payment. See OAR 410-123-1200 for more detail on codes not to be billed separately.¶
(b) Approved ancillary codes for all members include D7990, D9211, D9212, D9220, D9221, D9222, D9239, D9310, and D9997.¶
(c) D9248 is covered for clients under age 21 and limited to four times per year for clients under 13 years of age. Includes payment for monitoring and Nitrous Oxide. Requires use of multiple agents to receive payment.¶
(d) D9410 is covered for all clients and shall be only used for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

ADOPT: 410-123-1660

NOTICE FILED DATE: 10/15/2021

RULE SUMMARY: Adopt Meaningful Language Access section

CHANGES TO RULE:

410-123-1660
Meaningful Language Access
(1) Providers shall take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in program services at all dental care visits, including Telehealth:¶
(a) The size or type of provider does not matter. All providers serving OHP clients shall tell patients that qualified health interpreter services are available free of charge. Interpreter services shall be timely and protect the privacy and independence of the person with LEP;¶
(b) Bilingual providers and staff may become Certified Health Care Interpreters after completing the requisite interpreter training and receiving a valid certificate from the Authority;¶
(c) The Authority's Health Care Interpreter Registry lists all qualified or certified Health Care Interpreters available for provider use;¶
(d) Fee-for-Service (FFS) dental providers may receive a $60 add-on fee, per date of service, for providing interpreter services to OHP clients. The addition of this add-on fee for FFS visits does not change CCO requirements related to reimbursement of qualified and certified HCIs for interpretation services.¶
(2) FFS Reimbursement for Interpreter Services; FFS oral health and dental providers who furnish Certified Health Care Interpreter (HCI) services to OHP clients are eligible to receive a $60 add-on fee per date of service. The Authority will cover this fee only when:¶
(a) The fee is billed in conjunction with a covered OHP service or medically necessary follow-up visit related to the initial Covered Service;¶
(b) The fee is not billed in conjunction with bundled rate services that incorporate administrative costs (e.g., inpatient hospital stays, home health or hospice visits, services provided by long-term care facilities, or services billed at an encounter rate by rural health clinics, federally qualified health centers and tribal health centers); and¶
(c) The language assistance service is provided by a qualified or Certified Health Care Interpreter as described in Oregon Revised Statute (ORS) Chapter 413.¶
(3) Billing: Providers shall verify that the interpreter is registered with the Authority's Health Care Interpreter Registry. If the interpreter is registered, providers pay the interpreter directly for services provided. After payment is made to the interpreter, bill the Authority for the add-on fee on the claim form:¶
(a) Use CDT code D9990 for dental visits;¶
(b) Use HCPCS code T1013 for medical visits;¶
(c) Add the code to a new line on the claim form;¶
(d) Keep Documentation in the client's medical record that indicates use of the qualified or certified Health Care Interpreter for any potential audit of services billed.
Statutory/Other Authority: ORS 414.572, 413.550
Statutes/Other Implemented: ORS 414.572, 413.550