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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
06/22/2023 10:28 AM
ARCHIVES DIVISION
SECRETARY OF STATE

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

FILING CAPTION: Clarify Coverage Requirements And Align Dental Rules With Other Rules and CCO Contracts

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 07/21/2023 5:00 PM

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

A public rulemaking hearing may be requested in writing by 10 or more people, or by a group with 10 or more members, within 21 days following the publication of the Notice of Proposed Rulemaking in the Oregon Bulletin or 28 days from the date the Notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

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NEED FOR THE RULE(S)

The rule changes are to (1) align the dental urgent timeline with other rules, with the CCO contracts, and other standards. (2) Clarify coverage requirements for screening and evaluation; billing codes D0191 and D0190.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

None

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

Rule changes are designed to benefit all Oregonians who meet the eligibility requirements, and do not have a specific racial equity component.

FISCAL AND ECONOMIC IMPACT:

No impact anticipated.

COST OF COMPLIANCE:

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

1. No cost of compliance is anticipated for state agencies, units of local government or the public.
2.
a. Some dental clinics and associated services such as billing entities that do business with the Oregon Health plan will be subject to these changes. The number is unknown.

b. We anticipate these will remain the same for dental practices, OHP members and medical assisted programs.
c. We anticipate these will remain the same for dental practices, OHP members and medical assisted programs.

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

Small businesses were solicited to participate in our Rules Advisory Committee (RAC) held June 6th, 2023. Some RAC participants represented the interests of small businesses. Small businesses will also be able to give input during the public comment period.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-123-1060, 410-123-1260

AMEND: 410-123-1060

RULE SUMMARY: The rule changes are due to (1) aligning the dental urgent timeline with other rules, with the CCO contracts and other standards, and (2) Clarify coverage requirements for screening and evaluation; billing codes D0191 and D0190.

CHANGES TO RULE:

410-123-1060
Definition of Terms ¶

(1) "Abuse" has the meaning as provided in OAR 410-120-0000.¶
(2) "Acute" has the meaning as provided in OAR 410-120-0000.¶
(3) "Ambulatory 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) "Citizenship Waived Medical" has the meaning as provided in OAR 410-120-0000. The acronym "CWM" has the same meaning.¶
(9) "CMS-416" means the 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 hygienist 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:¶
(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 the Authority; and¶
(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 the Authority.¶
(12) "Dental" means conditions having to do with the teeth and supporting structures.¶
(13) "Dental Care Organization" (DCO) .¶
(14) "Dental Care Organization" (DCO) as provided for in ORS 414.025-(24) means a pre-paid managed care health services organization that provides, either by contract with a coordinated care organization or through other mechanisms~~,~~ ~~(i;~~ ¶
(a) dental services to the coordinated care organization's members, on a pre-paid capitated basis; or ~~(ii~~¶
(b) administrative services on behalf of the coordinated care organization as they relate to the delivery of dental

services, including, without limitation: provider credentialing, prior authorization or denial of services, or encounter claims processing; or ~~(iii)~~¶
(c) or both of the foregoing.¶
(15) "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.¶
(16) "Dental Hygienist" has the meaning as provided in OAR 410-120-0000.¶
(17) "Dental Hygienist with Expanded Practice Dental Hygiene Permit (EPDH)" has the meaning as provided in OAR 410-120-0000.¶
(18) "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.¶
(19) "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 Expanded Practice Permit (EPP).¶
(20) "Dental Services Documentation" means meeting the requirements of the Oregon Dental Practice Act statutes, administrative rules for client records and requirements of OAR 410-120 1360 Requirements for Financial, Clinical and Other Records, and any other Documentation requirements as outlined in OAR chapter 410 division 123 (Dental rules).¶
(21) "Dental Emergency Condition" means any 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;¶
(b) The treatment of an emergency dental condition is limited only to Covered 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 to those non-Covered Service.¶
(22) "Dental Therapist" has the meaning provided in ORS 679.010.¶
(23) "Dentally Appropriate" has the meaning as provided in 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 Oregon Dental Practice Act statutes, administrative rules for client records and requirements of OAR 410-120 1360 Requirements for Financial, Clinical and Other Records, and any other documentation requirements as outlined in OAR chapter 410 division 123 (Dental rules).¶
(28) "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services" means the federally mandated comprehensive and preventative 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 services.¶
(29) "Fee-for-Service Provider" has the meaning as provided in OAR 410-120-0000.¶
(30) "Fraud" has the meaning as provided in OAR 410-120-0000.¶
(31) "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.¶
(32) "Health Systems Division" has the meaning as provided in OAR 410-120-0000, 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.¶
(34) "Interpreter Services" means services available to those with Limited English Proficiency (LEP) as described in Title VI of the Civil Rights Act of 1964; Section 1557 of the Affordable Care Act; and ORS 413.550 for Meaningful Language Access Interpreter services may also be accessed 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).¶
(35)-"Managed Care Entity (MCE)" is a general term that means an entity that enters into one or more contracts with the Authority to provide services in a managed care delivery system, including but not limited to the following types of entities defined in and subject to 42 CFR Part 438: managed care organizations (MCOs),

primary care case managers (PCCMs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs). A CCO is an MCE for its managed care contract(s) with the Authority, without regard to whether the contract(s) involves federal funds or state funds or both.¶
(36) "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.¶
(37) "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.¶
(38) "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.¶
(43) "Physician" has the meaning as provided in OAR 410-120-0000.¶
(44) "Prepaid Ambulatory Health Plans" has the meaning provided in 42 CFR 438.2. The acronym "PAHP" has the same meaning.¶
(45) "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.¶
(46) "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.¶
(47) "Prior Authorization" has the meaning as provided in OAR 410-120-0000. The acronym "PA" has the same meaning.¶
(48) "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.¶
(49) "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.¶
(50) "Provider" has the meaning as provided in OAR 410-120-0000.¶
(51) "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.¶
(52) "Standard of Care" means what reasonable and prudent practitioners would do in the same or similar circumstances.¶
(53) "Teledentistry" means the modes 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.¶
(54) "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.¶
(55) "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 sh~~ould~~all 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. ~~M~~Pregnant members shall be seen or treated for Urgent Dental care within one week and non-pregnant members 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: 410-123-1260

RULE SUMMARY: The rule changes are due to (1) aligning the dental urgent timeline with other rules, with the CCO contracts and other standards, and (2) Clarify coverage requirements for screening and evaluation; billing codes D0191 and D0190.

CHANGES TO RULE:

410-123-1260
OHP Dental Benefits ¶

(1) This administrative rule aligns with and reflects changes 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 Dental 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) Dental S~~ervices in Primary Care Sett~~creenings ~~–~~(D0190 ~~or~~) and Assessments (D0191):¶
(a) ~~Reimbursement is available to certified FFS and MCE Primary Care Providers who deliver a dental evaluation, family dental 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 dental assessment to other staff member~~The assessment tool used shall be endorsed by the American Dental Association, the American Academy of Pediatric Dentistry, the Association of State and Territorial Dental Directors, or the American Academy of Pediatrics;¶
(~~C~~b) ~~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 sh~~D0190 may be used up to once per year. Dental screenings, including state or federally m~~eet 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)~~andated screenings, are to determine an individual's need to be seen by a dentist for diagnosis. Reimbursement for D0190 is for enrolled providers who hold a certificate of completion from Smiles for Life~~;¶~~
~~(ii)~~ or First Tooth.~~;~~ ¶
(~~C~~c) ~~Perform dental 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 Dental 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.~~D0191 may be used up to once per year. Dental assessments are limited inspections performed to identify possible signs of oral systemic disease, malformation, or injury, and the potential need for referral diagnosis and treatment. ¶
(A) Reimbursement for D0191 is for the following enrolled provider types: Licensed or certified dental professionals whose scope of practice includes assessing oral health; ¶
(~~E~~B) ~~Make r~~Referral ~~to a Dentist for FFS members or to the CCO member's assigned dental plan in orde~~s for identified dental needs or for t~~o~~he 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~~ment of a dental home are to be made to the member's primary care dentist~~, refer the patient to their dental home for dental care~~ for FFS members, or to the member's CCO;¶
(~~F~~C) Provide anticipatory guidance and counseling with the client's caregiver on good dental hygiene practices and nutrition;¶
(~~G~~D) Document in the medical chart risk assessment findings and service components provided.¶
(~~c~~d) Topical fluoride treatment - D1206 or 99188:¶
(A) May be applied during any well-child visit for children under 2~~1~~9 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 dental 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~~e) 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 Dental 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 dental 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 dental 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, 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-dental 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-dental complete series. The minimum standards for reimbursement of intra-dental 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 dental conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily Dental Health Care.¶
(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 dental health factors are clearly documented in chart notes for clients who:¶
(i) Have high-risk dental conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;¶
(ii) Are pregnant;¶
(iii) Have physical disabilities and cannot perform adequate, daily Dental Health Care;¶
(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily Dental Health Care; or¶
(v) Are under seven years old with high-risk dental health factors, such as poor dental hygiene, deep pits, and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.¶
(D) Fluoride limits include any combination of fluoride varnish or other topical fluoride.¶

(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 dental 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): When used to represent silver diamine fluoride (SDF) applications for the treatment (rather than prevention) of caries, is limited to:¶
(A) Two applications per year;¶
(B) Requires that the tooth or teeth numbers be included on the claim;¶
(C) Shall be covered with topical application of fluoride when performed on the same date of service when treating a carious lesion;¶
(D) 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 dental 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, diagnosis, and treatment 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 dental 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 dental 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 dental 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 MCE 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 an MCE. The client would not be eligible for another partial until February 3, 2030, regardless of MCE 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 dental condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily dental 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 dental condition and results in additional tooth loss. This pertains to, but is not

limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily dental 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 dental 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 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): Billing Procedures:¶
(a) Bill on a dental claim form using CDT codes for procedures that are directly related to the teeth and the structures directly supporting teeth;¶
(b) The Medical/Surgical Program is responsible for all dental health procedures performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, roof of mouth). Such procedures 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.¶
(f) Alveoloplasty not in conjunction with extractions are reimbursable for members under age 21, and for pregnant individuals (D7320, D7321).¶
(12) ORTHODONTICS (D8000-D8999):¶
(a) Orthodontia services including for cosmetic purposes are not covered except as in (b) of this rule.¶
(b) The Division covers orthodontia services and extractions to treat craniofacial malocclusions, anomalies, cleft lip or cleft palate with cleft lip, and handicapping malocclusions 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; and¶
(D) The Authority approves the request for fee-for-service coverage.¶
(c) Payment and prior authorization for CCO covered services is made by CCO's pursuant to the terms of their contract with OHA, and the provisions of (a) and (b) if this section. Payment and prior authorization requirements in (c) through (k) of this section are for the "fee for service" program.¶
(d) PA is required for orthodontia treatment;¶
(e) Documentation in the client's record shall include diagnosis, length, and type of treatment;¶
(f) Payment for appliance therapy includes the appliance and all follow-up visits;¶
(g) 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;¶
(h) 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;¶
(i) The Division shall use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;¶
(j) 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;¶
(k) 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 dental 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) Dental 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 dental 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) Dental 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) Dental 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 dental 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