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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
10/15/2020 1:10 PM
ARCHIVES DIVISION
SECRETARY OF STATE

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

FILING CAPTION: Division 123 Dental Program Rules Update

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2020 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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Filed By:
Brean Arnold
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NEED FOR THE RULE(S):

These rules are being amended to bring them into compliance with current federal regulations, current clinical standards and to better reflect the current state of the Medicaid fee-for-service dental program.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

OHP Dental Program Rules: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1711; OAR 410-120-1360 through 410-120-1580: http://www.oregon.gov/OHA/HSD/OHP//Pages/Policy-General-Rules.aspx, https://www.cms.gov/About-CMS/Components/CPI/CPI-Landing

FISCAL AND ECONOMIC IMPACT:

Amending these rules will have no fiscal impact on the Authority, other state agencies, units of local government, the public, or businesses, including small businesses.

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) Amending these rules will have no fiscal impact on the Authority, other state agencies, units of local government, the public, or businesses, including small businesses.
2a-c) None anticipated.

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

Through a Rule Advisory Committee process held on 7/16, 8/19 and 9/15, 2020.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

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

AMEND: 410-123-1000

RULE SUMMARY: Rule 410-123-1000 defines: (1) Oral health provider responsibilities to verify eligibility and Medicaid service limits of recipient before the rendering of services, (2) procedures for the billing and payment of Medicaid covered dental services, (3) financial and clinical records documentation mandates, and (4) gives reference to the new online data base of covered and non-covered dental services. This rule protects the Oregon Health Authority (OHA) and oral health providers from claim denials related to eligibility and billing.
Changes:
Proposed rule amendments change rule caption title to be consistent with language updates and repeal of rule 410-123-1100. Amendments to OAR 410-123-1000 rule language reflect the removal of the words, "Division of Medical Assistance Programs (Division)" to "Health Systems Division" (HSD) as the current Division name. This amendment also consolidates rule 410-123-1100, Services Reviewed by the Division of Medical Assistance Programs (Division), with rule 41-123-1000, repealing 410-123-1100. Other text is revised to improve readability and to provide necessary "housekeeping" corrections.

CHANGES TO RULE:

410-123-1000
Eligibility, ~~Providing Services and Billing~~ Services Reviewed by the Division, Billing and the Dental Billing Invoice
(1) Eligibility:¶
(a) Providers are responsible ~~to~~for verif~~y~~ication of client eligibility and must do so before providing any service or billing the ~~Division of Medical Assistance Programs~~Oregon Health Authority, Health Systems Division (Division) or any Oregon Health Plan (OHP) ~~Prepaid Health Plan (PHP~~Managed Care Entitiy (MCE);¶
(b) The Division may not pay for services provided to an ineligible client even if services were authorized. Refer to General Rules OAR 410-120-1140 (Verification of Eligibility) for details.¶
(2) ~~Co-~~Services Reviewed by the Health Services Division (Division):¶
(a) Services requiring prior authorization (PA): See OAR 410-123-1160 and 410-120-1320 for information about services that require PA or how to request PA.¶
(b) By Report Procedures:¶
(A) Request for payment~~s~~ for ~~OHP clients may be required for certain services. See General Rules~~dental services listed as "by report" (BR) must be submitted with a full description of the procedure, including relevant operative or clinical history reports and/or radiographs. Payment for BR procedures will be approved in consultation with a Division dental consultant;¶
(B) Refer to the "Covered and Non-Covered Dental Services" data base, as referenced in OAR 410-120~~3~~3-123~~0~~60, for ~~specific information on co-pays~~a list of procedures noted as BR. See OAR 410-123-1220.¶
(3) Billing:¶
(a) Providers must follow the Division rules in effect on the date of service. All Division rules are intended to be used in conjunction with the Division's General Rules Program (chapter 410, division 120), the OHP Administrative Rules (chapter 410, division 141), Pharmaceutical Services Rules (chapter 410, division 121) and other relevant Division OARs applicable to the service provided, where the service is delivered, and the qualifications of the person providing the service including the requirement for a current signed provider enrollment agreement;¶

(b) Providers must comply with OAR 410-120-1280 Billing rules and OAR 410-120-1360 requirements to develop and maintain adequate financial and clinical records and other documentation that supports the specific care, items, or services for which payment has been requested;¶
(A) Authority will only pay for services that are adequately documented.¶
(B) Documentation must support the dates of service, the amounts billed, the specific services provided, who provided the services, and the medical necessity of those services.¶
(C) Financial records must indicate that the amount billed to the Authority was appropriate and that all other resources were pursued before billing the Authority.¶
(D) FFS providers must keep clinical information on file for seven years, and financial records five years. Providers contracted with an MCE must retain all clinical records for a minimum of ten (10) years after the date of services for which claims are made, OAR 410-141-3520. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the retention period, the clinical records must be retained until all issues arising out of the action are resolved.¶
(c) Third Party Resources: A third party resource (TPR) is an alternate insurance resource, other than the Division, available to pay for medical/dental services and items on behalf of OHP clients. Any alternate insurance resource must be billed before the Division or any OHP ~~PHP~~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;¶
(~~c~~d) F~~abricated Prosthetics:¶~~
~~(A) If a dentist or denturist provides an eligible client with fabrica~~or Medicaid covered services, the provider must not:¶
(A) Bill the Authority more than the provider's usual charge (see definitions) or the reimbursement specified in the applicable Authority program rules;¶
(B) Bill the client for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the client or the Authority; ¶
(C) Bill the client for services or treatments that have been denied due to provider error (e.g., required documentation not submitted, pr~~osthetics that require the use of a dental laboratory, the date of the final impressions mus~~ior 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 cha~~ve occurred:¶~~
~~(i) Prior to the client's loss of eligibility; and¶~~
~~(ii) For dentu~~nge, 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 requires~~d~~ for ~~adults age 21 and older, no later than six months from the date of the last extraction from the jaw for which the dentur~~certain services. See General Rules OAR 410-120-1230 for specific information on co-pays;¶
(g) Refer to OAR 410-123-1160 for information regarding dental services requiring prior authorization (PA); ¶
(h) The client's records must include documentation to support the appropriateness of the service and level of care rendered;¶
(i) The Division shall only reimburse for dental services that are dentally appropriate ~~i~~as ~~being provided~~defined in OAR 410-123-1060;¶
(~~B~~j) ~~The dentist/denturist should use the date of final impression as the date of service onl~~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 ~~w~~then ~~criteria in (A) is met and the fabrication extends beyond:¶~~
~~(i) The client's OHP eligibility; or¶~~

(ii) Six months after the extrac dentist and patient shall establish appointment sequencing. Eligibility for medical assistance programs does not entitle a client to any services or consideration not provided to all clients.¶
(4) Billing Invoice:¶
(a) Providers: Refer to the Dental Services Provider Guide for information regarding claims submissions and billing information.¶
(b) Providers billing dental services on paper must use the 2019 version of the American Dental Associations (for dentures for adults);ADA) claim form.¶
(c) Submission of electronic claims directly or through an agent must comply with the Electronic Data Interchange (EDI) rules. OAR 943-120-0100 et seq.¶
(Cd) The date of delivery must be within 45 daySpecific 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 ofn the date of the final impression 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 the date of delivery must also be indicated on the claim. These are the only exceptions to the Division's General Rules Program rule 410-120-1280. Allat payment of the claim will be from federal and state funds, and that any falsification, or concealment of material fact, may be prosecuted under federal and state laws. Submission of a claim or encounter does not relieve the provider from the requirement of a signed provider enrollment agreement.¶
(5) A provider enrolled with the Authority must bill using the Authority assigned provider number, or the National Provider Identification (NPI) number, pursuant to OAR 410-120-1260;¶
(6) Unless other services must be billed using the date the service was provided;wise specified, claims must be submitted after: ¶
(a) Delivery of service; or ¶
(b) Dispensing, shipment or mailing of the item. ¶
(d7) Refer to OAR 410-123-1160 forThe provider must submit true, accurate and complete information regarding dental services requiring prior authorization (PA). Refer to 410-123-1100 for information regarding dental services that requirewhen 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 to submit reports for review ("by report" - BR) prior to reimbursement;, 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; ¶
(eC) The client's records must include documentation to support the appropriateness of the service and level of care renderAny claim upon which payment has been made or is expected to be made by another source until after the other source has been billed, with the exception of OAR 410-120-1280(10)(c)(A-D). If the other source denies the claim or pays less than the Medicaid allowable amount, a claim may be submitted to the Authority. Any amount paid by the other source must be clearly entered on the claim form and must include the appropriate TPR Explanation Code in box 9 of the appropriate claim form or in the appropriate field if electronically submitted in a manner authorized; ¶
(fD) The Division shall only reimburse for dental services that are dentally appropriate as defined in OAR 410-123-1060;¶
(g) 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);Any claim for furnishing specific care, items, or services that has not been provided;¶
(E) Any claim for specific care, items or services that is not supported by the documentation, the member's treatment or care plan, as applicable, and compliant with program specific rules. All documentation must be

complete and signed by the rendering provider prior to submitting a claim the Authority or MCE for payment.¶
(c) If an overpayment has been made by the Authority, the provider is required to do one of the following within 30 calendar days of the date on which the overpayment was identified: ¶
(A) Adjust the original claim to show the overpayment as a credit in the appropriate field; or¶
(B) Submit an Individual Adjustment Request (OHP 1036); or¶
(4C) ~~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 establish~~Adjust the claim on the Provider Web Portal available online at all times at: https://www.or-medicaid.gov; or¶
(D) Refund the amount of the overpayment on any claim; or¶
(E) Void the claim via the Provider Web Portal if the Authority overpaid due to erroneous billing; ¶
(F) If the overpayment occurred because of a payment from a third party payer refer to OAR 410-120-1280(10)(f) Billing rule.¶
(8) Procedure code requirement: ¶
(a) For claims requiring a procedure code the provider must bill as instructed in the appropriate Authority program rules and must use the appropriate HIPAA procedure code set such as CPT, HCPCS, ICD-10-PCS, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided; ¶
(b) For claims that require the listing of a procedure code as a condition of payment, the reported procedure code must be supported by the ~~dentist and patient shall establish appointment sequencing. Eligibility for medical assistance programs does not entitle a client to any services or consi~~client's medical record and the codes that most accurately describes the services provided. All providers, including Hospitals, billing the Authority must follow national coding guidelines;¶
(c) When there is no appropriate descriptive procedure code to bill the Authority, the provider must use the code for "unlisted services." A complete and accurate description of the specific care, item, or service must be documented on the claim; ¶
(d) Where there is one CPT, CDT, or HCPCS code that according to CPT, CDT, and HCPCS coding guidelines or standards describes an array of services, the provider must bill the Authority using that code rat~~ion not provided to all client~~her than itemizing the services under multiple codes. Providers may not "unbundle" services.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

ADOPT: 410-123-1025

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

Reason for adoption:

The Oregon Health Authority, operating as the State Medicaid Agency (SMA) for administering and supervising Oregon's Medicaid plan, has financial responsibility of any improper payments identified through program integrity activities. All Medicaid programs must meet federal requirements and coordinate with federal program integrity efforts. Basis of authority is in Section 1936 of the Social Security Act (the Act) which provides that entities under contract with the Centers for Medicare & Medicaid Services' (CMS) can audit claims for payment for items and services furnished under a state plan as well as identify overpayments made to individuals or entities receiving federal funds under Medicaid to determine whether fraud, waste, or abuse has occurred or is likely to occur. The creation of OAR 410-123-1025 brings oral health programs into compliance with Oregon's State Plan Amendment and current federal program integrity and audit rules and regulations.

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 fraud, waste and abuse in the Medicaid program. OAR 410-120-1360 through 410-120-1580 generally describe Authority program integrity activities related to Medicaid providers and payment. Providers enrolled with the Authority or under contract with the Authority or the Department of Human Services (DHS) receiving payments from the Authority or DHS are subject to audit or other post payment review procedures for all payments applicable to items or services furnished or supplied by the provider to or on behalf of Authority or DHS clients.¶
(2) Providers must comply with OAR 410-120-1510, OAR 461-195-0601 and the requirements therein for prompt reporting of fraud, waste and abuse in the Medicaid program:¶
(a) Providers must report all suspected fraud, waste and abuse by a provider, including fraud, waste or abuse by its employees or in the Authority administration, to the Medicaid Fraud Control Unit (MFCU) of the Department of Justice (DOJ) or to the Authority's Office of Program Integrity (OPI). Information on how to report may be found online at all times: https://www.oregon.gov/oha/FOD/PIAU/Pages/Report-Fraud.aspx.¶
(b) Providers must report all suspected fraud or abuse by an Authority or DHS client to the DHS's Office of Payment and Recovery (OPAR) Fraud Investigations Unit (FIU). Information on how to report may be found online at all times: http://www.oregon.gov/OHA/HSD/OHP//Pages/Policy-General-Rules.aspx.¶
(c) Authority will take all actions necessary to investigate and respond to credible allegations of fraud, waste and abuse in the Medicaid program, including but not limited to suspending or terminating the provider from participation in the medical assistance programs, withholding payments or seeking recovery of payments made to the provider, or imposing other sanctions provided under OAR 410-120-1400, state laws or regulations. These actions and any outcome(s) will be reported to CMS, or other federal or state of Oregon entities, or law enforcement, as appropriate.¶
(3) Providers delivering goods or services to OHP members and receiving payment under Oregon's medical assistance programs may be audited by the Authority, MFCU, Oregon Secretary of State, the Department of Health and Human Services (DHHS), or their authorized representatives.¶
(a) The audit rules and procedures applicable to oral health providers and MCE participating providers are in OAR 407-120-1505. The Authority conducts periodic audits of providers to ensure proper payments are made based

on requirements applicable to covered services, to ensure program integrity of the Authority or DHS medical programs as outlined in OAR 410-120-1260 and OAR 407-120-0310, recover overpayments and uncover possible instances of fraud, waste, and abuse. ¶

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

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

(d) Access to records, inclusive of medical charts and financial records does not require authorization or release from a member if the purpose is:¶

(A) To perform billing review activities; ¶

(B) To perform utilization review activities;¶

(C) To review quality, quantity, and medical appropriateness of care, items, and services provided; ¶

(D) To facilitate payment authorization and related services; ¶

(E) To investigate a client's contested case hearing request; ¶

(F) To facilitate investigation by the MFCU or DHHS; or¶

(G) Where review of records is necessary to the operation of the program.¶

(e) If a provider determines that a submitted claim or encounter is incorrect, the provider is obligated to submit, within 30 calendar days of the date on which the overpayment was identified, an Individual Adjustment Request and refund the amount of the overpayment, if any, consistent with the requirements of OAR 410-120-1280. When the provider determines that an overpayment has been made, the provider must notify and reimburse the Authority immediately, following the reimbursement procedures in OAR 410-120-1397.¶

(f) Upon written request from the Authority, MFCU, Oregon Secretary of State, the DHHS, law enforcement agency or their authorized representatives the provider must furnish, at the providers expense, requested documentation immediately or within the time-frame specified in the request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of the Authority, Department, MFCU, or DHHS may, together or separately, review and copy the original documentation in the provider's place of business. ¶

(g) Payment may be denied or subject to recovery if a review or audit determines the care, service or item was not provided in accordance with Authority rules or does not meet the criteria for quality or medical appropriateness of the care, service or item or payment.¶

(h) PIAU will use the sampling methods and calculation of overpayment methodology outlined in OAR 410-120-1397. When the Authority determines that an overpayment has been made to a provider, the amount of overpayment is subject to recovery.¶

(i) Prior to identifying an overpayment, the Authority or designee may contact the provider for the purpose of providing preliminary information and requesting additional documentation. Provider must provide the requested documentation to Authority within the time frames requested, unless any good cause for an extension in OAR 410-120-1395 is shown.¶

(j) When an overpayment is identified, Authority will notify the provider in writing, as to the nature of the discrepancy, the method of computing the dollar amount of the overpayment, and any further action that the Authority may take in the matter. ¶

(k) The provider may appeal an Authority notice of overpayment in the manner provided in OAR 410-120-1580.¶

(A) All Authority administrative review decisions are subject to procedures established in OAR 410-120-1580 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 410-120-1600. ¶
(L) When overpayment is identified in an audit finding, the Authority may recover overpayments made to a provider by direct reimbursement, offset, civil action, or other actions authorized by law.¶
(m) Authority will suspend provider enrollment and any payments, all or in part, when a credible allegation of fraud exists pursuant to federal law under 42 CFR 455.23, whether presented to the Authority, DHS, DOJ MFCU, or law enforcement entity; unless there is a pending investigation and good cause exists to continue payment.¶
(n) In addition to any overpayment, Authority may impose sanctions on a provider in connection with the actions that resulted in the overpayment or pursue other remedies specific to contract(s) between the provider and Authority.¶
(4) Provider sanctions in OAR 410-120-1400 may result in suspension or termination of the provider enrollment and the provider's Division assigned provider number.¶
(5) Authority may communicate with and coordinate any program integrity actions with the MFCU, DHS, and other federal and state oversight authorities.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1060

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

Changes:

OAR 410-123-1060 amends program term definitions which define new and revised oral health program requirements. Terms used within the oral health program rules are defined to achieve clarity in the statement and purpose of the rule of Oregon law, regulation and oversight of Medicaid programs.

CHANGES TO RULE:

410-123-1060
Definition of Terms ¶

(1) "Anesthesia" The following depictcute" has the Hmealth System Division, Medical Assistance Programs' (Division) usage of certain anesthesia terms; however, for further detailsning as provided in OAR 410-120-0000.¶
(2) "Ambulatory Surgical Center (ASC)" has the meaning as provided in OAR 410-120-0000.¶
(3) "Ancillary Service" has the meaning as provided in OAR 410-120-0000.¶
(4) "Anesthesia" refer alsos to the Oregon Board of Dentistry administrative rules (OAR chapter 818, division 026):. ¶
(a5) "Conscious Sedation" means the following:¶
(A) "Deep Sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance maintaiAnesthesia 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 patient airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained;rovided in OAR 410-120-0000.¶
(B7) "Minimal Sedation" means a minimally depressed level of consciousness produced by non-intravenous pharmacological methods that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. When the intent is minimal sedation for adults, the appropriate initial dosing of a single non-intravenous pharmacological method is no more tCurrent 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" hans the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. Nitrous oxide/oxygen may be used in combination with a single non-intravenous pharmacological method in minimal sedation;eaning as provided in OAR 410-120-0000. The acronym "CAWEM" has the same meaning.¶
(C9) "Moderate Sedation" means a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.¶
(b) "General Anesthesia" means a drug-induced loss of consciousness during which the patient is not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaiCo-Payments" means the portion of a claim or medical, dental, or pharmaceutical expense that a client must pay out of their own pocket to a provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See OAR 410-120-1230 Client Copayment.)¶
(10) "Covered Services" has the meaning as patient airway, and positive pressure ventilation may be required

because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired;¶
(c) "Local Anesthesia" meansrovided in OAR 410-120-0000.¶
(11) "COVID-19 Emergency" means the period: 1. Starting on the earliest of any COVID-19 public health emergency affecting the delimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug;¶
(d) "Nitrous Oxide Sedation" means an induced controlled state of minimal sedation produced solely by the inhalation of a combinativery of health care services and declared by the Secretary of HHS pursuant to 42 U.S.C. 247d, by the Governor of Oregon, of nitrous oxide and oxygen in whichr by OHA; and 2. Ending on the platient retains the ability to independently and continuously maintain an airway and to respond purposefully to physical stimulation and to verbal command.¶
(2) Citizen/Alien-Waived Emergency Medical (CAWEM). Refer to OAR 410-120-0000 for definition of clients who are eligible for limited emergency services under the CAWEM benefit package. The definition of emergency services does not apply to CAWEM clients. OAR 410-120-1210 provides a complete description of limited emergency coverageest of any COVID-19 public health emergency affecting the delivery of health care services and declared by the Secretary of HHS pursuant to 42 U.S.C. 247d, by the Governor of Oregon, or by OHA. OHA will publish guidance on the CCO Contracts Website regarding the duration of the COVID-19 Emergency. This pertainings to the CAWEM benefit package.¶
(3) "Covered Services" means services on the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) that have been funded by the legislature and identified in specific program rules. Services are limited as directed by General Rules Excluded Services and Limitations (OAR 410-120-1200), the Division's Dental Services Program rules (chapter 410, division 123), and the Prioritized List. Services that are not considered eleniencies under HIPAA and delivery modalities provided in telehealth/teledentistry due to the COVID-19 Emergency. See OAR 410-120-1990.¶
(12) "Dental" means having to do with the teeth.¶
(13) "Dental Emergency dental services as defined by section (12) of this rule are considered routine services Services" has the meaning as provided in OAR 410-120-0000.¶
(14) "Dental Hygienist" means has the mean-individual licensed to practice dental hygiene pursuant to state lawg as provided in OAR 410-120-0000.¶
(15) "Dental Hygienist with Expanded Practice Dental Hygiene Permit (EPDH)" means an individual licensed to practice dental hygiene with an EPDH permit issued by the Board of Dentistry and within the scope of an EPDH permit pursuant to state lawhas the meaning as provided in OAR 410-120-0000.¶
(16) "Dental Practitioner" means an individual licensed pursuant to state law to engage in the provision of dental services within the scope of the practitioner's license and certification.¶
(17) "Dental Services" has the meaning as provided in OAR 410-120-0000, and means services provided within the scope of practice as defined under state law by or under the supervision of a dentist or dental hygienist or denture services provided within the scope of practice as defined under state law by a denturist or Limited Access Permit (LAP).¶
(18) "Dental Services Documentation" means meeting the requirements of the Oregon Dental Practice Act statutes;, administrative rules for client records and requirements of OAR 410-120- 1360 Requirements for Financial, Clinical and Other Records, and any other documentation requirements as outlined in OAR chapter 410 division 123 (Dental rules).¶
(19) "Dentaly Appropriate" means services that are required for prevention, diagnosis, or treatment of a dental condi Emergency Condition" means a condition based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results. Dental Emergency Condition may include but is not limited to severe tooth pain, unusual swelling, or an avulsed tooth. ¶
(20) "Dental Urgent Care" focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and that are:¶

~~(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;¶~~
~~(b) Appropriate with regard to standards of good dental p~~o alleviate the burden on hospital emergency departments. These should be treated as minimally invasively as possible. Examples of Dental Urgent Care Conditions include: Severe dental pain from pulpal inflammation; Pericoronitis or third-molar pain; Surgical post-operative osteitis; Dry socket dressing changes; Abscess, or localized bacterial infection resulting in localized pain and swelling; Tooth fracture resulting in pain or causing soft tissue trauma; Dental trauma with avulsion/luxation; Dental treatment required prior to critical medical procedures; Final crown/bridge cementation if the temporary restoration is lost, broken or causing gingival irritation; Biopsy of abnormal tissue; Extensive dental caries or defective restorations causing pain, managed with interim restoractic~~e and generally recognized by the relevant scientific community, evidence-based medicine,~~ve techniques when possible (silver diamine fluoride, glass ionomers); Suture removal; Denture adjustment on radiation/ oncology patients; Denture adjustments or repairs when function impeded; Replacing temporary filling on endo access openings in patients experiencing pain; Snipping or adjustment of an orthodontic wire or appliances piercing or ulcerating the oral mucosa.¶
(21) "Dentally Appropriate" as provided in OAR 410-120-0000, means health services, items, or dental supplies: ¶
(a) Recommended by a licensed health provider practicing within the scope of their license; ¶
(b) Safe, effective and appro~~fessional standards of care as effectiv~~priate for the patient based on standards of good dental practice and generally recognized by the relevant scientific or professional community based on the best available evidence; ¶
(c) Not solely for the convenience o~~f an OHP~~r 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 o~~f dental~~r types of health services, items, or supplies that are covered services that can be safely ~~provided to a member.¶~~
~~(10) "Dentist" means an individual licensed to practic~~and effectively provided to a client or member in the Division or MCE's judgement. ¶
(e) All Covered Services must be ~~d~~Dent~~istry pursuant to state law.¶~~
~~(11) "Denturist" means an individual licensed to practice denture technology pursuant to state law~~ally Necessary or Dentally Appropriate for the Member or Client, but not all Dentally Necessary or Dentally Appropriate services are Covered Services.¶
(22) "Dentist" has the meaning as provided in OAR 410-120-0000.¶
(~~12~~3) "D~~irect Pulp Cap" means the procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes h~~enturist" has the meaning as provided in OAR 410-120-0000.¶
(24) "Distant Site" means the site where the dentist is being contacted for consultation by the originating site.¶
(25) "Division" has the mea~~l~~ning a~~nd repair~~s provided in OAR 410-120-0000.¶
(~~13~~26) "Emergency ~~Services means:¶~~
~~(a) Covered services for an emergency dental~~Medical Condition" has the same meaning as OAR 410-120-0000 and means a condition manifesting itself by acute symptoms of sufficient severity ~~requiring immediate treatment. This includ~~(including severe pain) such that a prudent layperson, who posses-se~~rvices to treat the following conditions:¶~~
~~(A) Acute infection;¶~~
~~(B) Acute abscesses;¶~~
~~(C) Severe tooth pain;¶~~
~~(D) Unusual swelling of the face or gums; or¶~~
~~(E) A tooth that has been avulsed (knocked out).¶~~
~~(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 services. Routine dental tre~~s an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.¶

(27) "Emergency Services" has the meaning as provided in OAR 410-120-0000 and means health services from a qualified provider necessary to evaluate or stabilize an emergency dental or medical condition, including inpatient and outpatient treatment that may be necessary to assure within reasonable medical probability that the pat~~m~~i ent ~~or treatment of incipient decay does not constitute emergency care (See also~~'s condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.¶
(28) "Fee-for-Service Provider" has the meaning as provided in OAR 410-120-0000~~)~~.¶
(~~14~~29) "Hospital Dentistry" means dental services normally done in a dental office setting but due to specific client need (as detailed in OAR 410-123-1490) are provided in an ambulatory surgical center, inpatient or outpatient hospital setting under general anesthesia, or IV conscious sedation, if appropriate.¶
(~~15~~30) "Managed Care Entity (MCE)" has the meaning as provided in OAR 410-141-3500.¶
(31) "Managed Care Organization (MCO)" has the meaning as provided in OAR 410-120-0000.¶
(32) "Medical Practitioner" means an individual licensed pursuant to state law to engage in the provision of medical services within the scope of the practitioner's license and certification.¶
(~~16~~33) "Medicament" means a substance or combination of substances intended to be pharmacologically active, specially prepared to be prescribed, dispensed, or administered to prevent or treat disease.¶
~~(17) "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.¶~~
~~(18) "Standard of Care" means what reasonable and prudent practitioners would do in the same or similar circumstances~~34) "Originating Site" means the site where the patient is located, and dental care providers are working and performing services in conjunction with a dentist who is not at that site, all while using telehealth technology.¶
(35) "Physician" has the meaning as provided in OAR 410-120-0000.¶
(36) "Prepaid Ambulatory Health Plans" has the meaning provided in 42 CFR 438.2. The acronym "PAHP" has the same meaning. ¶
(37) "Prepaid Health Plan" and "PHP" each has the meaning as provided in OAR 410-120-0000.¶
(38) "Primary Care Dentist (PCD)" as stated in OAR 410-120-0000, means a dental practitioner responsible for supervising and coordinating initial and primary dental care within their scope of practice for their members. ¶
(39) "Primary Care Provider (PCP)" as stated in OAR 410-120-0000, means any enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified clients. PCPs initiate referrals for care outside their scope of practice, consultations, and specialist care and assure the continuity of medically appropriate client care. A Federally qualified PCP means a physician with a specialty or subspecialty in family medicine, general internal medicine, or pediatric medicine as defined in OAR 410-130-0005. ¶
(40) "Prior Authorization" has the meaning as provided in OAR 410-120-0000. The acronym "PA" has the same meaning.¶
(41) "Procedure Codes" means the procedure codes set forth in OAR chapter 410, division 123 that refer to Current Dental Terminology (CDT), unless otherwise noted. Codes listed in this rule and other documents incorporated in rule by reference are subject to change by the American Dental Association (ADA) without notification.¶
(42) "Provider" has the meaning as provided in OAR 410-120-0000.¶
(43) "Referral" as stated in OAR 410-120-0000, means the transfer of total or specified care of a client from one provider to another. As used by the Authority, the term referral also includes a request for a consultation or evaluation or a request or approval of specific services. ¶
(44) "Standard of Care" means what reasonable and prudent practitioners would do in the same or similar circumstances.¶
(45) "Teledentistry" means the modalities specified in OAR 410-123-1265, using electronic and telecommunications technologies, for the distance delivery of dental care services and clinical information

designed to improve a patient's health status and to enhance delivery of the health care services and clinical information.¶

(46) "Telehealth" means for the purposes of OAR 410-123-1265, OAR 410-120-1990 and as specified in ORS 679.543, a variety of methods using electronic and telecommunications technologies for the distance delivery of health care services, including dental care services and clinical information designed to improve a patient's health status and to enhance delivery of the health care services and clinical information.

Statutory/Other Authority: ORS 413.042, ORS 414.065

Statutes/Other Implemented: ORS 414.065

REPEAL: 410-123-1100

RULE SUMMARY: This rule change repeals 410-123-1100 to consolidate with rule 410-123-1000 “Eligibility, Services Reviewed by the Division, Billing and the Dental Billing Invoice”.

CHANGES TO RULE:

~~410-123-1100~~
~~Services Reviewed by the Division of Medical Assistance Programs (Division)~~
~~(1) Services requiring prior authorization (PA): See OAR 410-123-1160 for information about services that require PA and how to request PA.¶~~
~~(2) By Report Procedures:¶~~
~~(a) Request for payment for dental services listed as "by report" (BR), or services not included in the procedure code listing must be submitted with a full description of the procedure, including relevant operative or clinical history reports and/or radiographs. Payment for BR procedures will be approved in consultation with a Division of Medical Assistance Program (Division) dental consultant;¶~~
~~(b) Refer to the "Covered and Non-Covered Dental Services" document for a list of procedures noted as BR. See OAR 410-123-1220.¶~~
~~(3) Treatment Justification: the Division may request the treating dentist to submit appropriate radiographs or other clinical information that justifies the treatment:¶~~
~~(a) Before issuing PA;¶~~
~~(b) In the process of utilization/post payment review; or¶~~
~~(c) In determining responsibility for payment of dental services.~~
~~Statutory/Other Authority: ORS 413.042, 414.065~~
~~Statutes/Other Implemented: ORS 414.065~~

AMEND: 410-123-1160

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

Changes:

Amendments to OAR 410-123-1160 rule language reflect the change of the words “Division of Medical Assistance Programs (Division)” to “Health Systems Division” (HSD) as the current Division name. Other text adds rule language to clarify program expectations, improve readability and to provide necessary “housekeeping” corrections.

CHANGES TO RULE:

410-123-1160
Prior Authorization
(1) ~~Division of Medical Assistance Programs~~Health Services Division (Division) prior authorization (PA) requirements: ¶
(a) For fee-for-service (FFS) dental clients, the following services require PA: ¶
(A) Crowns (porcelain fused to metal); ¶
(B) Crown repair; ¶
(C) Retreatment of previous root canal therapy - anterior; ¶
(D) Complete dentures; ¶
(E) Immediate dentures; ¶
(F) Partial dentures; ¶
(G) Prefabricated post and core in addition to fixed partial denture retainer; ¶
(H) Fixed partial denture repairs; ¶
(I) Skin graft; and ¶
(J) Orthodontics (when covered pursuant to OAR 410-123-1260); ¶
(b) Hospital dentistry always requires PA, regardless of the client's enrollment status. Refer to OAR 410-123-1490 for more information; ¶
(c) Oral surgical services require PA when performed in an ambulatory surgical center (ASC) or an outpatient or inpatient hospital setting and related anesthesia. Refer to OAR 410-123-1260 (Oral Surgery Services), and the current Medical Surgical Services administrative rule OAR 410-130-0200 for information; ¶
(d) Maxillofacial surgeries may require PA in some instances. Refer to the current Medical Surgical Services administrative rule 410-130-0200, for information. ¶
(2) The Division does not require PA for outpatient or inpatient services related to ~~life-threatening emergencies. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization. ¶~~
~~(3) How to request PA: ¶~~
~~(a) Submit the request to the Division in writing. Refer to the Dental Services Provider Guide for specific instructions and forms to use. Telephone calls requesting PA will not be accepted; ¶~~
~~(b~~a "Dental Emergency Condition" which means determination based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results. Dental Emergency Condition may include but is not limited to severe tooth pain, unusual swelling, or an avulsed tooth. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization. ¶
(3) How to request PA: ¶
(a) Submit the request to the Division in writing. Refer to the Dental Services Provider Guide for specific instructions and forms to use. Telephone calls requesting PA will not be accepted; ¶

(b) Documentation submitted when requesting authorization must support the medical justification for the service. The authorization request must contain:¶
(A) A cover sheet detailing relevant provider and recipient Medicaid numbers;¶
(B) Requested dates of service;¶
(C) HCPCS or Current Dental Terminology (CDT) Procedure code requested;¶
(D) Amount of service or units requested; and¶
(E) Any additional clinical information supporting medical justification for the services requested;¶
(c) Treatment justification: The Division may request the treating dentist to submit appropriate radiographs or other clinical information that justifies the treatment: ¶
(A) When radiographs are required, they must be: ¶
(i) Readable copies; ¶
(ii) Mounted or loose; ¶
(iii) In an envelope, stapled to the PA form; ¶
(iv) Clearly labeled with the dentist's name and address and the client's name; and ¶
(v) If digital x-ray, they must be of photo quality; ¶
(B) Do not submit radiographs unless it is required by the Dental Services administrative rules or they are requested during the PA process. ¶
(4) The Division will issue a decision on PA requests within 30 days of receipt of the request. The Division will provide PA for services when: ¶
(a) The prognosis is favorable; ¶
(b) The treatment is practical; ¶
(c) The services are dentally appropriate; and ¶
(d) A lesser-cost procedure would not achieve the same ultimate results. ¶
(5) PA does not guarantee client eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on ~~the~~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) ~~For managed care~~MCE PA requirements: ¶
(a) For services other than hospital dentistry, contact the client's Dental Care Organization (DCO) for PA requirements for individual services and/or supplies listed in the Dental Services administrative rules. DCOs may not have the same PA requirements for dental services as listed in this administrative rule; ¶
(b) For hospital dentistry, refer to OAR 410-123-1490 for details regarding PA requirements.
Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.707
Statutes/Other Implemented: ORS 414.065, 414.707

AMEND: 410-123-1220

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

CHANGES TO RULE:

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

(1) This rule incorporates by reference the "Covered and Non-Covered Dental Services" d~~ocument dated January 1, 2020, and located on the Health Systems Division (Division) website at~~ata base located at: https://~~www~~data .oregon.gov/~~oha/HSD/OHP/Pages/Policy-Dental.aspx.~~Health-Human-Services/Oregon-Medicaid-Covered-and-Non-Covered-Dental-Cod/5t6q-5tkx/data and dated January 1, 2021. ¶
(a) The "Covered and Non-Covered Dental Services" d~~ocument~~ata base lists coverage of Current Dental Terminology (CDT) procedure codes according to the Oregon Health Evidence Review Commission (HERC) Prioritized List of Health Services (Prioritized List) and the client's specific Oregon Health Plan benefit package;¶
(b) This document is subject to change if there are funding changes to the Prioritized List. ¶
(2) Changes to services funded on the Prioritized List are effective on the date of the Prioritized List change: ¶
(a) The Division administrative rules (chapter 410, division 123) do not reflect the most current Prioritized List changes until the rules are amended through the Division rule filing process; ¶
(b) For the most current Prioritized List, refer to the HERC website at www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx; ¶
(c) In the event of an alleged variation between a Division-listed code and a national code, the Division shall apply the national code in effect on the date of request or date of service. ¶
(3) Refer to OAR 410-123-1260 and it's referenced data base for information about limitations on procedures funded according to the Prioritized List. Examples of limitations include frequency and client's age.¶
(4) The Prioritized List does not include or fund the following general categories of dental services, and the Division does not cover them for any client. Several of these services are considered elective or "cosmetic" in nature (i.e., done for the sake of appearance): ¶
(a) Desensitization; ¶
(b) Implant and implant services; ¶
(c) Mastique or veneer procedure; ¶
(d) Orthodontia (except when it is treatment for cleft palate, cleft lip, or cleft palate with cleft lip); ¶
(e) Overhang removal; ¶
(f) Procedures, appliances, or restorations solely for aesthetic or cosmetic purposes; ¶
(g) Temporomandibular joint dysfunction treatment; and ¶
(h) Tooth bleaching.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

REPEAL: 410-123-1240

RULE SUMMARY: Rule 410-123-1240 defines and clarifies the dental claim invoice process, dental co-payments, and Electronic Data Interchange (EDI) claim submission rules for oral health providers.

Reason for Repeal:

This rule change repeals 410-123-1240 “The Dental Claim Invoice”. Billing claims submission rules are re-written and clarified in rule 410-123-1000 “Eligibility, Services Reviewed by the Division, Billing and the Dental Billing Invoice”.

CHANGES TO RULE:

~~410-123-1240~~
~~The Dental Claim Invoice~~
~~(1) Providers: Refer to the Dental Services Provider Guide for information regarding claims submissions and billing information.¶~~
~~(2) Providers billing dental services on paper must use the 2012 version of the American Dental Association (ADA) claim form.¶~~
~~(3) Submission of electronic claims directly or through an agent must comply with the Electronic Data Interchange (EDI) rules. OAR 943-120-0100 et seq.¶~~
~~(4) Specific information regarding Health Insurance Portability and Accountability Act (HIPAA) requirements can be found on the Division Web site.¶~~
~~(5) Providers will not include any client co-payments on the claim when billing for dental services.~~
~~Statutory/Other Authority: ORS 413.042, 414.065~~
~~Statutes/Other Implemented: ORS 414.065~~

AMEND: 410-123-1260

RULE SUMMARY: The language of OAR 410-123-1260 clarifies how the Oregon Health Plan (OHP) covers newly opened Current Dental Terminology (CDT) codes and restored benefits as of October 1, 2016. The rule references the "Covered and Non-Covered Dental Services" database dated January 1, 2021, which houses all CDT codes, OHP coverage or non-coverage statuses, Health Evidence Review Commission (HERC) prioritized list lines, guideline note references and benefit limitations for oral health program providers.
Oral health providers are referred to the Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, eligible clients, and related services.
Changes:
Clarifying language was added to the rule further expanding on what the Agency means by the historical reference to "trauma" in the replacement of full and/or partial dentures. New language states: Full and partial dentures that the client owns may be replaced in cases of loss due to circumstances beyond the member's control or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster.
The bulk of benefit descriptions occur through a new dental benefit data base and incorporated in rule by reference - the "Covered and Non-Covered Dental Services" database dated January 1, 2021, is located on the Health Systems Division (Division) website at: https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-Covered-and-Non-Covered-Dental-Cod/5t6q-5tkx/data.
The revision of OAR 410-123-1260 updates the rule aligning it with current OHP dental benefits and current standards of care. A database has been created and included in OAR 410-123-1260 and OAR 410-123-1220 by reference at https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-Covered-and-Non-Covered-Dental-Cod/5t6q-5tkx/data. This database houses the dental benefits list previously available in OAR 410-123-1220 Covered/Non-Covered List and referenced in OAR 410-123-1260. All limitations found in OAR 410-123-1260 are identified in the data base, along with any other needed criteria.
Any elements not able to be included in the data base is included in the text narrative for OAR 410-123-1260, e.g. EPSDT requirements.

CHANGES TO RULE:

410-123-1260
OHP Dental Benefits ¶

~~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.¶~~
~~(1) GENERAL:¶~~
~~(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT):¶~~
~~(A) Refer to Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the EPSDT program, eligible clients, and related services. EPSDT dental services include but are not limited to:¶~~
~~(i) Dental screening services for eligible EPSDT individuals; and¶~~
~~(ii) Dental diagnosis and treatment that is indicated by screening at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.¶~~
~~(B) Providers shall provide EPSDT services for eligible Division clients according to the following documents:¶~~
~~(i) The Dental Services program administrative rules (OAR chapter 410, division 123), for dentally appropriate services funded on the Oregon Health Evidence Review Commission's Prioritized List of Health Services~~

(Prioritized List); and¶
(ii) The "Oregon Health Plan (OHP) - Recommended Dental Periodicity Schedule," dated April 1, 2018, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document athttps://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.¶
(2) ENHANCED ORAL HEALTH SERVICES IN PRIMARY CARE SETTINGS:¶
(a) Topical fluoride treatment:¶
(A) For children under 19 years of age, topical fluoride varnish may be applied by a licensed medical practitioner during a medical visit. Providers must bill:¶
(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;¶
(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;¶
(iii) Using a professional claim format with either the appropriate Current Dental Terminology (CDT) code (D1206-Topical Fluoride Varnish) or the appropriate Current Procedural Terminology (CPT) code (99188 - Application of topical fluoride varnish by a physician or other qualified health care professional).¶
(B) Topical fluoride treatment from a medical practitioner counts toward the overall maximum number of fluoride treatments, as described in subsection (4) of this rule.¶
(b) Assessment of a patient:¶
(A) For children under six years of age, CDT code D0191-Assessment of a Patient is covered as an enhanced oral health service in medical settings;¶
(B) For reimbursement in a medical setting, D0191-Assessment of a Patient must include all of the following components:¶
(i) Caries risk assessment using a standardized tool endorsed by Oregon Oral Health Coalition, the American Dental Association, the American Academy of Pediatric Dentistry, or the American Academy of Pediatrics;¶
(ii) Anticipatory guidance and counseling with the client's caregiver on good oral hygiene practices and nutrition;¶
(iii) Referral to a dentist to establish a dental home;¶
(iv) Documentation in medical chart of risk assessment findings and service components provided.¶
(C) For reimbursement, the performing provider must meet all of the following criteria:¶
(i) Be a physician (MD or DO), an advance practice nurse, or a licensed physician assistant; and¶
(ii) Hold a certificate of completion from one of the following approved training programs within the previous three years:¶
(I) Smiles for Life; or¶
(II) First Tooth through the Oregon Oral Health Coalition.¶
(D) For reimbursement, the medical practitioners must bill:¶
(i) The Division directly when the client is fee-for-service (FFS), is enrolled in a Coordinated Care Organization (CCO) that does not include integrated medical and dental services, or is enrolled in a PHP that does not include integrated medical and dental services;¶
(ii) The client's CCO if the client is enrolled in a CCO that includes integrated medical and dental services;¶
(iii) Using a professional claim format with the appropriate CDT code (D0191-Assessment of a Patient).¶

(E) D0191-Assessment of a Patient may be reimbursed under this subsection up to a maximum of once every 12 months;¶
(F) D0191-Assessment of a Patient from a medical practitioner does not count toward the maximum number of CDT code D0191-Assessment of a Patient services performed by a dental practitioner described in section (3) of this rule.¶
(c) For tobacco cessation services provided during a medical visit, follow criteria outlined in OAR 410-130-0190.¶
(3) DIAGNOSTIC SERVICES:¶
(a) 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 must 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;¶
(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;¶
(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) Radiographs:¶
(A) The Division shall reimburse for routine radiographs once every 12 months;¶
(B) The Division shall reimburse bitewing radiographs for routine screening once every 12 months;¶
(C) The Division shall reimburse a maximum of six radiographs for any one emergency;¶
(D) For clients under age six, radiographs 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 (D0330) or intra-oral complete series (D0210) 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 (D0210). 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 full mouth complete series (D0210), 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.¶
(4) PREVENTIVE SERVICES:¶
(a) 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;¶
(D) Are coded using the appropriate Current Dental Terminology (CDT) coding:¶
(i) D1110 (Prophylaxis - Adult) - Use for clients 14 years of age and older; and¶
(ii) D1120 (Prophylaxis - Child) - Use for clients under 14 years of age.¶
(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 (D1206) or other topical fluoride (D1208).¶
(c) Sealants (D1351):¶
(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 brief counseling is provided:¶
(i) Ask patients about their tobacco-use status at each visit and record information in the chart;¶
(ii) Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and a strong personalized message to seek help; and¶
(iii) Refer patients who are ready to quit, utilizing internal and external resources, to complete the remaining three A's (assess, assist, arrange) of the standard intervention protocol for tobacco.¶
(B) The Division allows a maximum of ten services within a three-month period.¶

(e) Space management:¶
(A) The Division shall cover fixed and removable space maintainers (D1510, D1515, D1520, D1525, and D1575) 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):¶
(A) Is limited to silver diamine fluoride (SDF) application as the medicament. It does not include coverage of any other medicaments;¶
(B) May be billed for two applications per year;¶
(C) Requires that the tooth or teeth numbers be included on the claim;¶
(D) Shall be covered with topical application of fluoride (D1206 or D1208) when they are performed on the same date of service if D1354 is being used to treat a carious lesion and D1206 or D1208 to prevent caries;¶
(E) Shall be covered with an interim therapeutic restoration (D2941) or a permanent restoration and (D1354) on the same tooth, when dentally appropriate.¶
(5) RESTORATIVE SERVICES:¶
(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 (D2941) is covered to restore and prevent progression of dental caries. Interim therapeutic restoration is not a definitive restoration;¶
(H) Reattachment of tooth fragment (D2921) 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 (D2950) 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 must be remaining for coverage of the core buildup.¶
(iv) Reimbursement of retention pins (D2951) 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) Stainless steel crowns (D2930/D2931) 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 plastic crowns (D2932) are allowed only for anterior teeth, permanent or primary;¶
(ii) Prefabricated stainless-steel crowns with resin window (D2933) are allowed only for anterior teeth, permanent or primary;¶
(iii) Prefabricated post and core in addition to crowns (D2954/D2957);¶
(iv) Permanent crowns (resin-based composite - D2710 and D2712 and porcelain fused to metal (PFM) - D2751 and D2752) 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 according to (E)(i) of this rule;¶
(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) PFM crowns (D2751 and D2752) 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 (D2980) is limited to only anterior teeth.¶
(6) ENDODONTIC SERVICES:¶
(a) Endodontic therapy:¶
(A) Pulpal therapy on primary teeth (D3230 and D3240) is covered only for clients under 21 years of age;¶
(B) For permanent teeth:¶
(i) Anterior and bicuspid endodontic therapy (D3310 and D3320) is covered for all OHP Plus clients; and¶
(ii) Molar endodontic therapy (D3330):¶
(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 (D3430) 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.¶
(7) PERIODONTIC SERVICES:¶
(a) Surgical periodontal services:¶
(A) Gingivectomy/Gingivoplasty (D4210 and D4211) - limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia; 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 (D4341 and D4342):¶
(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 5 mm or greater:¶
(I) D4341 is allowed for quadrants with at least four or more teeth with pockets 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 (D4355) allowed only once every two years.¶
(C) (D4346) 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 (D4910) 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).¶
(8) REMOVABLE PROSTHODONTIC SERVICES:¶
(a) Clients age 16 years and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140);¶
(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 (D5211-D5212):¶
(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, 2002 and becomes a FFS OHP client in 2005. The client is not eligible for a replacement partial until February 1, 2007. The client gets a replacement partial on February 3, 2007 while FFS and a year later enrolls in a DCO or CCO. The client would not be eligible for another partial until February 3, 2012, 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 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) Adjusting complete and partial dentures, per arch (D5410-D5422);¶
(ii) Replacing missing or broken teeth on a complete denture, each tooth (D5520);¶
(iii) Replacing broken tooth on a partial denture, each tooth (D5640);¶
(iv) Adding tooth to existing partial denture (D5650).¶
(B) A maximum of two times per year for:¶
(i) Repairing broken complete denture base (D5510);¶
(ii) Repairing partial resin denture base (D5610);¶
(iii) Repairing partial cast framework (D5620);¶
(iv) Repairing or replacing broken clasp (D5630);¶
(v) Adding clasp to existing partial denture (D5660).¶
(g) Replacement of 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; and¶
(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 (D5820-D5821, 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.¶
(9) MAXILLOFACIAL PROSTHETIC SERVICES:¶
(a) Fluoride gel carrier (D5986) 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 or PHP, bill medical maxillofacial prosthetics to the CCO or PHP;¶
(C) For clients receiving medical services through FFS, bill the Division.¶
(10) ORAL SURGERY SERVICES:¶
(a) Bill the following procedures in an accepted dental claim format using CDT codes:¶
(A) Procedures that are directly related to the teeth and supporting structures that are not due to a medical condition or diagnosis, including such procedures performed in an ambulatory surgical center (ASC) or an inpatient or outpatient hospital setting;¶
(B) Services performed in a dental office setting or an oral surgeon's office:¶
(i) Such services include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs, and follow-up visits;¶
(ii) Refer to OAR 410-123-1160 for any PA requirements for specific procedures.¶
(b) Bill the following procedures using the professional claim format and the appropriate American Medical Association (AMA) CPT procedure and ICD-10 diagnosis codes:¶
(A) Procedures that are a result of a medical condition (i.e., fractures, cancer);¶
(B) Services requiring hospital dentistry that are the result of a medical condition/diagnosis (i.e., fracture, cancer).¶
(c) Refer to the "Covered and Non-Covered Dental Services" document to see a list of CDT procedure codes on the Prioritized List that may also have CPT medical codes. See OAR 410-123-1220. The procedures listed as "medical" on the table may be covered as medical procedures, and the table may not be all-inclusive of every dental code that has a corresponding medical code;¶
(d) For clients enrolled in a DCO or CCO responsible for dental services, the DCO or CCO shall pay for those services in the dental plan package;¶
(e) Oral surgical services performed in an ASC or an inpatient or outpatient hospital setting:¶
(A) Require PA;¶
(B) For clients enrolled in a CCO, the CCO shall pay for the facility charge and anesthesia services. For clients enrolled in a Physician Care Organization (PCO), the PCO shall pay for the outpatient facility charge (including ASCs) and anesthesia. Refer to the current Medical Surgical Services administrative rules in OAR chapter 410, division 130 for more information;¶
(C) If a client is enrolled in a CCO or PHP, the provider shall contact the CCO or PHP for any required authorization before the service is rendered.¶
(f) All codes listed as "by report" require an operative report;¶
(g) The Division covers payment for tooth re-implantation only in cases of traumatic avulsion where there are good indications of success;¶
(h) Biopsies collected are reimbursed as a dental service. Laboratory services of biopsies are reimbursed as a medical service;¶
(i) The Division does not cover surgical excisions of soft tissue lesions (D7410-D7415);¶
(j) Extractions - Includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service;¶
(k) Surgical extractions:¶
(A) Include local anesthesia and routine post-operative care;¶
(B) The Division limits payment for surgical removal of impacted teeth or removal of residual tooth roots to treatment for only those teeth that have acute infection or abscess, severe tooth pain, or unusual swelling of the face or gums;¶
(C) The Division does not cover alveoloplasty in conjunction with extractions (D7310 and D7311) separately from

the extraction;¶
(D) The Division covers alveoplasty not in conjunction with extractions (D7320-D7321) only for clients under 21 years of age or who are pregnant.¶
(L) Frenulectomy/frenulotomy (D7960) and frenuloplasty (D7963):¶
(A) The Division covers either frenulectomy or frenuloplasty once per lifetime per arch only for clients under age 21;¶
(B) The Division covers maxillary labial frenulectomy only for clients age 12 through 20;¶
(C) The Division shall cover frenulectomy/frenuloplasty in the following situations:¶
(i) When the client has ankyloglossia;¶
(ii) When the condition is deemed to cause gingival recession; or¶
(iii) When the condition is deemed to cause movement of the gingival margin when the frenum is placed under tension.¶
(m) The Division covers excision of pericoronal gingival (D7971) only for clients under age 21 or who are pregnant.¶
(11) ORTHODONTIA SERVICES:¶
(a) The Division limits orthodontia services and extractions to eligible clients:¶
(A) With the ICD-10-CM diagnosis of:¶
(i) Cleft palate; ¶
(ii) Cleft lip; or¶
(iii) Cleft palate with cleft lip.¶
(B) Whose orthodontia treatment began prior to 21 years of age; or¶
(C) Whose surgical corrections of cleft palate, cleft lip, or cleft palate with cleft lip that were not completed prior to age 21.¶
(b) PA is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate, cleft lip, or cleft palate with cleft lip shall be included in the client's record and a copy sent with the PA request;¶
(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 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.¶
(12) ADJUNCTIVE GENERAL AND OTHER SERVICES:¶
(a) Fixed partial denture sectioning (D9120) 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 (D9223 and D9243);¶~~
~~(B) The Division reimburses providers for general anesthesia or IV sedation as follows:¶~~
~~(i) D9223 or D9243: For each 15-minute period, up to three and a half hours on the same day of service;¶~~
~~(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 (D9230) per date of service, not by time;¶~~
~~(D) Oral pre-medication anesthesia for conscious sedation (D9248):¶~~
~~(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 (D9410) 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 for these codes using the professional claim format~~(1) This administrative rule aligns with and reflects changes to the Prioritized List of Health Services and the American Dental Association's (ADA) Code on Dental Procedures and Nomenclature (CDT Codes), as well as a restoration of benefits resulting from legislative action in 2015. Effective January 1, 2017, the Health Evidence Review Commission (HERC) added and deleted oral health procedure codes. This rule provides information on how the Oregon Health Plan covers newly opened CDT codes and restored benefits as of October 1, 2016. Incorporated by reference the "Covered and Non-Covered Dental Services" database dated January 1, 2021, is located on the Health Systems Division (Division) website at: https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-Covered-and-Non-Covered-Dental-Cod/5t6q-5tkx/data. All CDT codes, OHP coverage or non-coverage statuses, prioritized list lines, guideline note references and benefit limitations are found in the above referenced database. Instructions for database use can be found in the Dental Services Provider Guide: https://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx.¶
(2) GENERAL:¶
(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT):¶
(A) Refer to Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the EPSDT program, eligible clients, and related services. EPSDT dental services include but are not limited to:¶
(i) Dental screening services for eligible EPSDT individuals; and¶
(ii) Dental diagnosis and treatment that is indicated by screening at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.¶
(B) Providers shall provide EPSDT services for eligible Division clients according to the following documents:¶
(i) The Dental Services program administrative rules (OAR chapter 410, division 123), for dentally appropriate services funded on the Oregon Health Evidence Review Commission's Prioritized List of Health Services (Prioritized List); and¶
(ii) The "Oregon Health Plan (OHP) - Recommended Dental Periodicity Schedule," dated April 1, 2018, incorporated in rule by reference and posted on the Division website in the Dental Services Provider Guide document at: https://www.oregon.gov/OHA/HSD/OHP/Pages/Policy-Dental.aspx.¶
(b) Restorative, periodontal, and prosthetic treatments:¶
(A) Documentation shall be included in the client's charts to support the treatment. Treatments shall be consistent with the prevailing standard of care and may be limited as follows:¶

(i) When prognosis is unfavorable;¶
(ii) When treatment is impractical;¶
(iii) A lesser-cost procedure achieves the same ultimate result; or¶
(iv) The treatment has specific limitations outlined in this rule.¶
(B) Prosthetic treatment, including porcelain fused to metal crowns, are limited until rampant progression of caries is arrested and a period of adequate oral hygiene and periodontal stability is demonstrated; periodontal health needs to be stable and supportive of a prosthetic.¶
(c) Full and/or partial denture replacement: For indications and limitations of coverage and dental appropriateness, the Division may cover reasonable and necessary replacement of dentally appropriate, covered full and/or partial dentures, including those items purchased or in use before the client enrolled with the Division.¶
(A) Replacement of full and/or partial dentures because of loss due to circumstances beyond the member's control, accident or natural disaster/ Situations involving the provision of dentally appropriate items when: ¶
(i) There is a change in the client's condition that warrants a new device; ¶
(ii) The item is not repairable; and ¶
(iii) There is coverage for the specific item as identified in chapter 410, division 123.¶
(iv) Full and partial dentures that the client owns may be replaced in cases of loss due to circumstances beyond the member's control or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster. ¶
(C) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of full and/or partial dentures may not be covered. All other dental services are represented in the above referenced Dental Benefits Database.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1265

RULE SUMMARY: The language in 410-123-1265 defines teledentistry as utilizing telehealth systems for oral care specifically through synchronous and asynchronous forms (i.e. live video and mobile communication devices). This rule clarifies general billing requirements and teledentistry billing requirements necessary for payment of oral health services performed within the dental health program's scope of practice.

Changes:

Rule amendment 410-123-1265 separates and makes distinct the meaning of telehealth and teledentistry. The use of telehealth refers to a broad variety of technologies to deliver a wide variety of virtual health services, while teledentistry refers to the use of telehealth systems for oral care specifically. Teledentistry can include patient care and education using a variety of electronic modalities, which expands Medicaid service delivery options for Oregonians. The need for the current changes is to migrate the definitions previously within OAR 410-123-1265 to the Oregon Administrative General Rules – OAR 410-120 and to change the prior references to the Medical/Surgical rule OAR 410-130, re: Telehealth- to the Oregon Administrative General Rule – 410-120 where the Telehealth rule resides, effective January 1, 2021.

CHANGES TO RULE:

410-123-1265
Teledentistry

(1) ~~For the purposes of this rule and as specified in ORS 679.543, "Telehealth" means 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.¶~~

~~(2) "Teledentistry" means the modalities specified in section (5) of this rule, 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. ¶~~

~~(3) "Distant Site" means the site where the dentist is being contacted for consultation by the originating site.¶~~

~~(4) "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. ¶~~

~~(5)~~ 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 ~~and,~~ health care ~~and,~~ public health practices, and education.¶

(~~6~~2) All billing requirements stated in this rule apply to all delivery modalities referenced in section (5) of this rule.¶

(~~7~~3) Billing Provider Requirements, as referenced in OAR 410-13~~2~~0-~~061~~1990:¶

(a) Dentists providing Medicaid services must be licensed to practice dentistry within the State of Oregon or within the contiguous area of Oregon and must be enrolled as a Health Systems Division (Division) provider;¶

(b) Providers billing for covered teledentistry/telehealth services are responsible for the following:¶

(A) Complying with Health Insurance Portability and Accountability Act (HIPAA) and Oregon Health Authority (Authority) Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records. ~~Examples of applicable Authority Confidentiality and Privacy~~

~~Rules include: OAR 943-120-0170, 410-120-1360 and 410-120-1380, and OAR 943, division 14. Examples of federal and state privacy and security laws that may apply include, if applicable, HIPAA (45 CFR Parts 160, 162, and 164), and 42 CFR Part 2, and ORS 646A.600 to 646A.628 (Oregon Consumer Identity Theft Protection Act);~~ See OAR 410-120-1990.¶
(B) Obtaining and maintaining technology used in the telehealth communication that is compliant with privacy and security standards in HIPAA and Department Privacy and Confidentiality Rules described in subsection (5)(b)(A);¶
(C) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized individuals;¶
(D) Maintaining clinical and financial documentation related to telehealth services as required in OARs 410-120-1360 and 410-120-1990.¶
(c) A patient receiving services through teledentistry shall be notified of the right to receive interactive communication with the distant dentist and shall receive an interactive communication with the distant dentist upon request; ¶
(d) The patient's chart documentation shall reflect notification of the right to interactive communication with the distant site dentist;¶
(e) A patient may request to have real time communication with the distant dentist at the time of the visit or within 30 days of the original visit.¶
(~~8~~4) General Billing Requirements:¶
(a) Unless authorized in OAR 410-120-1200 Exclusions or OAR 410-13~~2~~0-~~0610 Telemedicine~~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. ¶
(~~9~~5) Teledentistry billing requirements:¶
(a) The dentist who completes diagnosis and treatment planning and the oral evaluation also documents these services using the traditional CDT codes. This provider also reports the teledentistry event using D9995 or D9996 as appropriate. See the Dental Billing Instructions for details at: www.oregon.gov/oha/HSD/OHP/Pages/Policy-Dental.aspx;¶
(b) The originating site may bill a CDT code only if a separately identifiable service is performed within the scope of practice of the practitioner providing the service. The service must meet all criteria of the CDT code billed.¶
(~~10~~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