Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form.

Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division)			410
Agency and Division			Administrative Rules Chapter Number
Cheryl Peters	500 Summer St NE, Salem, OR 97301		503-945-6527
Rules Coordinator	Address		Telephone

RULE CAPTION

Expand age for varnish in medical setting and update language for dental integration

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

11/15/13	10:30	500 Summer St NE, Salem, OR 97301, Room 137C	Cheryl Peters
Hearing Date	Time	Location	Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

AMEND: 410-123-1260

REPEAL:

RENUMBER:

AMEND & RENUMBER:

Stat. Auth. : ORS 413.042 and 414.065

Other Auth.:

Stats. Implemented: ORS 414.065

RULE SUMMARY

Revises language based on Health Evidence Review Commission's Prioritized List changes for October 1, 2013. Clarifies billing to avoid ambiguity regarding the responsibility of Coordinated Care Organizations (CCO).

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

11/18/13 by 5:00 p.m.

Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

[signature]	Judy Mohr Peterson	10/14/2013
Signature	Printed name	Date

*Hearing Notices published in the Oregon Bulletin must be submitted by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a weekend or legal holiday, upon which the deadline is 5:00 pm the preceding workday. ARC 920-2005

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority, Division of Medical Assistance Programs (Division) — 410
Agency and Division — Administrative Rules Chapter Number

Expand age for varnish in medical setting and update language for dental integration
Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The proposed amendment of OAR 410-123-1260

Statutory Authority: ORS 413.042 and 414.065
Other Authority:

Stats. Implemented: ORS 414.065

Need for the Rule(s): Revises language based on Health Evidence Review Commission's Prioritized List changes for October 1, 2013. Clarifies billing to avoid ambiguity regarding the responsibility of Coordinated Care Organizations (CCO).

Documents Relied Upon, and where they are available:

Fiscal and Economic Impact:

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):
The Division does not anticipate fiscal impacts on other state agencies, units of local government or the public. Fluoride varnish is already a covered service through dental; increasing the age limit of fluoride varnish reimbursement to medical providers would not be a new benefit, but a new delivery model. To the extent that use of the preventative measure increases, any increase in cost is expected to result in net savings from reduced treatment cost for caries.

2. Cost of compliance effect on small business (ORS 183.336):
a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:
The types of small businesses include small dental offices. However, our system does not flag which dental providers are part of a larger clinic or corporation, therefore we are unable to estimate the number of small businesses that are subject to the rules. There are approximately 3,700 licensed dentists in the entire State of Oregon, but there is no information on the number of dental office there are or the number that would be considered as a small business.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:
None anticipated

c. Equipment, supplies, labor and increased administration required for compliance:
None anticipated

How were small businesses involved in the development of this rule?
Administrative Rule Advisory Committee consulted?:
If not, why?:

The Division will sponsor a Rule Advisory Committee (RAC) meeting for provider, public and small business input. The meeting is scheduled for October 15. Approximately two weeks prior to this meeting, a public notice will be posted on the agency website and an invitation will be emailed to those who have expressed interest in the rule making process.

Judy Mohr Peterson — Judy Mohr Peterson — 10/14/2013
Signature — Printed name — Date

410-123-1260

OHP Plus Dental Benefits

(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 includes, but are not limited to:

(i) Dental screening services for eligible EPSDT individuals; and

(ii) Dental diagnosis and treatment which 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 must 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 Prioritized List of Health Services (Prioritized List); and

(ii) The "Oregon Health Plan (OHP) — Recommended Dental Periodicity Schedule," dated January 1, 2010, incorporated by reference and posted on the Division Web site in the Dental Services Provider Guide document at www.oha.state.or.us/policy/healthplan/guides/dental/main.html;

(b) Restorative, periodontal and prosthetic treatments:

(A) Treatments must be consistent with the prevailing standard of care, documentation must be included in the client's charts to support the treatment, and may be limited as follows:

(i) When prognosis is unfavorable;

(ii) When treatment is impractical;

(iii) A lesser-cost procedure would achieve 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) DIAGNOSTIC SERVICES:

(a) Exams:

(A) For children (under 19 years of age):

(i) The Division shall reimburse exams (billed as 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 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 should not bill D0140 and D0170 for routine dental visits;

(D) The Division only covers oral exams 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 furnished by a dental hygienist (with or without an expanded practice permit);

(b) Assessments 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. An oral assessment is included in the exam;

(iii) For children (under 19 years of age), a maximum of twice every 12 months; and

(iv) For adults (age 19 and older), a maximum of once every 12 months;

(B) When performed by a medical practitioner, the Division shall cover:

(i) Only for children under 7 years of age; and

(ii) A maximum of once a year;

(C) Medical practitioners performing D0191 shall bill the client's medical coverage for reimbursement (Coordinated Care Organization (CCO) or Prepaid Health Plan (PHP) if enrolled member, or Division if fee-for-service);

(D) The maximum limits for this procedure for dental practitioners do not affect the maximum limits for medical providers, and vice versa; and

(E) 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 must 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 10 periapicals and two bitewings for a total of 12 films;

(ii) For clients ages 12 and older - a minimum of 10 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 was unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records must be included in the client's records;

(K) Digital radiographs, if printed, should be on photo paper to assure sufficient quality of images.

(3) 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/or 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) For children under ~~7~~ 19 years of age, topical fluoride varnish may be applied by a medical practitioner during a medical visit:

(i) Bill the Division directly when the client is fee-for-service (FFS), is enrolled in a CCO that does not include integrated dental services, or is enrolled in a PHP that does not include integrated dental services ~~regardless of whether the client is fee-for-service (FFS) or enrolled in a CCO or a PHP~~;

(ii) Bill using a professional claim format with the appropriate CDT code (D1206 — Topical Fluoride Varnish);

(D) Additional topical fluoride treatments may be available, up to a total of 4 treatments per client within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for the following 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 year 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;

(E) Flouride 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 10 services within a three-month period;

(C) For tobacco cessation services provided during a medical visit follow criteria outlined in OAR 410-130-0190;

(e) Space management:

(A) The Division shall cover fixed and removable space maintainers (D1510, D1515, D1520, and D1525) only for clients under 19 years of age;

(B) The Division may not reimburse for replacement of lost or damaged removable space maintainers.

(4) RESTORATIVE SERVICES:

(a) Restorations — amalgam and composite:

(A) The Division shall cover resin-based composite restorations only for anterior teeth (D2330-D2390) and one surface posterior teeth (D2391);

(B) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;

(C) The Division reimburses posterior composite restorations at the same rate as amalgam restorations;

(D) 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 must 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) The Division reimburses for a surface once in each treatment episode regardless of the number or combination of restorations;

(H) The restoration fee includes payment for occlusal adjustment and polishing of the restoration;

(b) 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% of the tooth structure must be remaining for coverage of the core buildup. The Division may not cover core buildup if the crown is not covered under the client's OHP benefit package;

(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) The Division shall cover acrylic heat or light cured crowns (D2970 temporary crown, fractured tooth) — allowed only for anterior permanent 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) — allowed only for anterior teeth, permanent or primary;

(ii) Stainless steel crowns (D2930/D2931) — allowed only for anterior primary teeth and posterior permanent or primary teeth;

(iii) Prefabricated stainless steel crowns with resin window (D2933) — allowed only for anterior teeth, permanent or primary;

(iv) Prefabricated post and core in addition to crowns (D2954/D2957);

(v) 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;

(vi) PFM crowns (D2751 and D2752) must 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 410123-1100 (Services Reviewed by the Division of Medical Assistance Programs);

(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 millimeter and over, documentation must 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 tooth to be crowned is clasp/abutment tooth in partial denture, both prognosis for crown itself and tooth's contribution to partial denture must 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.

(5) ENDODONTIC SERVICES:

(a) Pulp capping:

(A) The Division includes direct and indirect pulp caps in the restoration fee; no additional payment shall be made for clients with the OHP Plus benefit package;

(B) The Division covers direct pulp caps as a separate service for clients with the OHP Standard benefit package because restorations are not a covered benefit under this benefit package;

(b) 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;

(c) Endodontic retreatment and apicoectomy/periradicular surgery:

(A) The Division does not cover retreatment of a previous root canal or apicoectomy/periradicular surgery 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;

(d) 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;

(e) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;

(f) Apexification/recalcification and pulpal regeneration procedures:

(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;

(B) Apexification/recalcification and pulpal regeneration procedures are covered only for clients under 21 years of age or who are pregnant.

(6) 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 gingivolplasty 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) For clients through age 20, allowed once every two years;

(ii) For clients age 21 and over, allowed once every three years;

(iii) A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;

(iv) 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;

(II) D4342 is allowed for quadrants with at least two teeth with pocket depths of 5 mm or greater;

(v) 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):

(i) For clients through age 20, allowed only once every 2 years;

(ii) For clients age 21 and older, allowed once every three years;

(c) Periodontal maintenance (D4910):

(A) For clients through age 20, allowed once every six months;

(B) For clients age 21 and older:

(i) Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;

(ii) Allowed once every twelve months;

(iii) 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 increase periodontal maintenance (chart notes, pocket depths and radiographs);

(d) Records must 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) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and

(H) D4910 (Periodontal maintenance).

(7) 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) The Division limits full dentures for clients age 21 and older to only those clients who are recently edentulous:

(A) For the purposes of this rule:

(i) "Edentulous" means all teeth removed from the jaw for which the denture is being provided; and

(ii) "Recently edentulous" means the most recent extractions from that jaw occurred within six months of the delivery of the final denture (or, for fabricated prosthetics, the final impression) for that jaw;

(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 must have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;

(C) For clients age 21 and older, the client must 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 mastification. Third molars are not a consideration when counting missing teeth;

(D) The dental practitioner must 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 and under 21 years of age - the Division shall replace full or partial dentures once every ten years, only if dentally appropriate. This does not imply that replacement of dentures or partials must be done once every ten years, but only when dentally appropriate;

(B) For clients 21 years of age and older - the Division may not cover replacement of full dentures, but shall cover replacement of partial dentures once every 10 years only if dentally appropriate;

(C) The 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 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, 2012. The client gets a replacement partial on February 3, 2012 while FFS and a year later enrolls in a DCO, CCO. The client would not be eligible for another partial until February 3, 2022, regardless of DCO, CCO or FFS enrollment;

(D) Replacement of partial dentures with full dentures is payable ten years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene 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 4 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 2 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 (D5670D5671):

(A) Is covered for clients age 16 and older a maximum of once every 10 years, per arch;

(B) Ten years or more must 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 10 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 must be documentation of a current reline which 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 5 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.

(8) 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 must 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.

(9) 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, 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 (including 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 ICD9 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, 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 or FCHP, the CCO or FCHP 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 must 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, and/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.

(10) ORTHODONTIA SERVICES:

(a) The Division limits orthodontia services and extractions to eligible clients:

(A) With the ICD-9-CM diagnosis of:

(i) Cleft palate; or

(ii) Cleft palate with cleft lip; and

(B) Whose orthodontia treatment began prior to 21 years of age; or

(C) Whose surgical corrections of cleft palate or cleft lip 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 or cleft lip must be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record must include diagnosis, length and type of treatment;

(d) Payment for appliance therapy includes the appliance and all follow-up visits;

(e) Orthodontists evaluate orthodontia treatment for cleft palate/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 must 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.

(11) 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 (D9220, D9221, D9241 and D9242);

(B) The Division reimburses providers for general anesthesia or IV sedation as follows:

(i) D9220 or D9241: For the first 30 minutes;

(ii) D9221 or D9242: For each additional 15-minute period, up to three hours on the same day of service. 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 must 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.

Stat. Auth.: ORS 413.042, 414.065 & 414.707
Stats. Implemented: ORS 414.065 & 414.707

~~Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 18-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 14-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 31-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 17-2011, f. & cert. ef. 7-12-11; DMAP 41-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12; DMAP 13-2013, f. 3-27-13, cert. ef. 4-1-13; DMAP 28-2013(Temp), f. 6-26-13, cert. ef. 7-1-13 thru 12-28-13~~