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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

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

FILED: 10/29/2026 3:41 PM
ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Benefit Update Project (BUP) revisions, improved clarity, reimbursement changes.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2026 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.

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Filed By:
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HEARING(S)
Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 11/16/2026
TIME: 11:00 AM - 11:45 AM
OFFICER: Brenna Bird

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 669-254-5252
CONFERENCE ID: 1658999856
SPECIAL INSTRUCTIONS:
Meeting ID: 165 899 9856
Passcode: 306967

NEED FOR THE RULE(S):

BUP revisions are to remove references to HERC's Prioritized List covered lines; improved clarity of OHP benefit, changes to teledentistry reimbursement.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None.

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

The population most affected by these rules changes are OHP members; and dental providers who serve OHP members. Dental providers in rural and that are small businesses will be impacted.

Feedback from the Rules Advisory Committee:

- There is a chance that the most marginalized communities will experience further marginalization as a result of reducing benefit coverage for certain preventative treatments. Rural, elderly, homebound, and low income communities may be hit harder than other communities by these benefit coverage changes.
- There may be greater impacts to providers offering dental services because of these rule changes.

FISCAL AND ECONOMIC IMPACT:

RAC members shared that there may be an upstream impact since the rule changes seem to change what is covered in terms of preventative dental services – there may be greater costs associated with treating more advanced diseases with late-stage interventions.

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) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s).
CCOs and Dental Subcontractors.

(2) Effect on Small Businesses:

(a) Estimate the number and type of small businesses subject to the rule(s);
There are approximately 400 to 500 small dental offices in the state that may be serving OHP members.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);
We do not anticipate a cost related to reporting, recordkeeping, and administrative activities since the rule changes are technical in nature and do not change administrative activities.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).
None

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

Small businesses, including dental providers, were invited to the Rules Advisory Committee on October 15 and October 20 to provide input on the fiscal impacts and discuss how to mitigate any fiscal impacts.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

410-123-1160, 410-123-1260, 410-123-1265

AMEND: 410-123-1160

RULE SUMMARY: Revise references to the Prioritized List to align with changes across Chapter 410.

CHANGES TO RULE:

410-123-1160
Prior Authorization
(1) The Authority covers the following services only with Prior Authorization (PA) approval:¶
(a) Crowns:~~-~~¶
(A) Porcelain fused to metal (D2751, D2752); and~~-~~¶
(B) Porcelain ceramic (D2740);¶
(b) Crown repair necessitated by restorative material failure (D2980), covered only for anterior teeth;¶
(c) Retreatment of previous root canal therapy (D3346), covered only for anterior teeth;¶
(d) ~~Complete d~~Dentures~~;~~¶
(e) ~~Immediate dentures;¶~~
~~(f) Partial dentures;¶~~
~~(g) Immediate partial~~Replacement of teeth on dentures~~;~~¶
(~~h~~f) Prefabricated post and core (D2954);~~-~~¶
(~~i~~g) Fixed partial denture repairs (D6980);¶
(~~j~~h) Skin graft (D7920);¶
(~~k) Comprehensive~~i) Orthodontic treatment ~~(D8070, D8080, D8090, D8091)~~;¶
(~~l~~j) Hospital dentistry (Refer to OAR 410-123-1490);¶
(~~m~~k) Oral surgical services, when performed in an:¶
(A) Ambulatory surgical center (ASC); or¶
(B) Outpatient or inpatient hospital setting and related anesthesia (Refer to OAR 410-130-0200); and¶
(~~n~~l) Maxillofacial surgeries, in some instances (Refer to OAR 410-130-0200).¶
(2) The Authority does not require PA for outpatient or inpatient services related to a "Dental Emergency Condition" as defined in OAR 410-123-1060:¶
(a) The member's medical record must document any appropriate clinical information that supports the need for the hospitalization; and¶
(b) Refer to the OHA Prioritized List of Health Services for ~~fund~~ covered emergency dental service codes.¶
(3) The frequency allowed for the following services may be increased with approved PA .¶
(a) Frequencies of Periodontal scaling and root planing (D4341, D4342), and scaling in the presence of generalized moderate to severe inflammation (D4346) may be increased from the once (1) every two (2) years limitation when:¶
(A) Medically necessary and dentally appropriate due to periodontal disease found during pregnancy or 12 months postpartum; and¶
(B) Documentation in the member's record that supports the need for increased scaling and root planing;¶
(b) The frequency of Periodontal maintenance (D4910) may be increased from the once (1) in six (6) months limitation when:¶
(A) Medically necessary and dentally appropriate due to periodontal disease found during pregnancy or 12 months postpartum;~~-~~¶
(B) Documentation in the member's record documents the need. Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth and clinical attachment loss charting and radiographs; and¶
(C) Periodontal maintenance is covered only following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three (3) years. ¶
(4) Hospital dentistry always requires PA for the medical services provided by the facility:¶
(a) If a member is enrolled in a C~~CO~~oordinated Care Organization (CCO) with plan type CCOA:¶
(A) The dental subcontractor or dental provider is responsible for:¶
(i) Contacting the CCO for PA requirements and arrangements; and¶
(ii) Submitting documentation to the CCO associated with the member record.¶
(B) The CCO must review the documentation and discuss any concerns they have, contacting the dentist as

needed; and¶
(C) The total response time must not exceed seven (7) calendar days from the date of receipt of all required documentation for routine dental care and must follow urgent or emergent dental care timelines.¶
(b) If a member is enrolled in a CCO with plan type CCOB;¶
(A) The dentist is responsible for:¶
(i) Contacting the CCO for PA requirements and arrangements; and¶
(ii) Submitting documentation to the CCO associated with the member record.¶
(B) The CCO shall review the documentation and discuss any concerns they have, contacting the dentist as needed. This allows for mutual plan (CCO and Fee-for-Service (FFS)) involvement and monitoring; and¶
(C) The CCO is responsible for payment of all facility and anesthesia services. The FFS program is responsible for payment of all dental services.¶
(c) If a member is enrolled in a CCO with plan type CCOF or CCOG and is enrolled in FFS for physical health:¶
(A) The dentist is responsible for sending, by secure email or faxing, documentation and a completed American Dental Association (ADA) form to the Authority (Refer to the Dental Services Provider Guide);¶
(B) The member must have prior approval from the CCO for dental services, and from the Authority for the facility payment;¶
(C) The Authority is responsible for payment of facility and anesthesia services;¶
(D) The CCO is responsible for payment of all dental services; and¶
(E) The Authority shall issue a decision on PA requests within seven (7) calendar days of date received.¶
(d) If a member is enrolled in F~~ee-for-Service~~FS for both physical health and dental health or enrolled in the C~~oordinated Care Organization~~CO plan type CCOE, the:¶
(A) Dental provider is responsible for sending, by secure email or faxing, documentation, and a completed ADA form to the Authority (Refer to the Dental Services Provider Guide); and¶
(B) Authority is responsible for payment of all facility, anesthesia services and dental services.¶
(5) How to request PA:¶
(a) Refer to www.oregon.gov/oha/HSD/OHP/Pages/PA.aspx or the Dental Services Provider Guide for specific instructions and forms to use. PA requests made by telephone or sent through the mail are not accepted;¶
(b) Submitted documentation must support the medical justification for the service. The PA request must contain:¶
(A) A cover sheet detailing relevant provider and recipient Medicaid numbers;¶
(B) Requested date(s) of service;¶
(C) Healthcare Common Procedure Coding System (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) The Authority recommends inclusion of appropriate digital radiographs with the original PA request submission; and other clinical information that justifies the treatment. Radiographs must be:¶
(A) Correctly identified of diagnostic quality; and¶
(B) Clearly labeled with the dental provider's name and address and the member's name.¶
(6) The Authority shall issue a decision on PA requests within seven (7) calendar days upon receipt of the request. The Authority shall provide PA for services when:¶
(a) The prognosis is favorable, which refers to a;¶
(A) Prediction that an individual's health condition is likely to improve or lead to a positive outcome; and¶
(B) Determination made by a healthcare provider based on medical evidence;¶
(b) The treatment is practical;¶
(c) The services are medically necessary and dentally appropriate; and¶
(d) A lesser-cost procedure may not achieve the same ultimate results.¶
(7) PA approval does not guarantee member eligibility or reimbursement for a future service date. It is the responsibility of the provider to check the member's eligibility on each date of service.¶
(8) The Authority may seek a general practice or specialist consultant for:¶
(a) Professional review to determine if a PA shall be approved; and¶
(b) Shall deny PA if the consultant decides that the clinical information furnished does not support the treatment of services.¶
(9) CDT billing codes are in accordance with Current Dental Terminology, © 202~~5~~7 American Dental Association. All rights reserved.
Statutory/Other Authority: ORS 413.042, ORS 414.065, 414.707
Statutes/Other Implemented: ORS 414.065, 414.707

AMEND: 410-123-1260

RULE SUMMARY: Revise references to the Prioritized List to align with changes across Chapter 410. Update rule language for clarity.

CHANGES TO RULE:

410-123-1260
Coverage, Limitations, Exclusions ¶

(1) The Oregon Health Authority (Authority) offers Oregon Health Plan (OHP) dental/denturist benefits to OHP Members~~.~~ as described in the State Plan and as further detailed in the OHA Prioritized List of Health Services defined in OAR 410-141-3820 (Covered Services). ¶
(a) The rules included in ~~C~~this OAR chapter 410, ~~D~~division 123 are specific to services provided on a Fee-for-Service (FFS) basis. ¶
(b) For additional requirements for Coordinated Care Organization (CCO) coverage, see ~~D~~division 141. ¶
(c) OHP Members who are Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Beneficiaries (as defined in OAR 410-151-0001) may be authorized to receive dental/denturist benefits that:¶
(A) Are not identified in the State Plan if those benefits are EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) as described in OAR chapter 410, division 151; and¶
(B) Exceed the amount, scope and duration identified in the OHA Prioritized List of Health Services and in the OAR chapter 410, division 123, if EPSDT Medically Necessary and EPSDT Medically Appropriate (or EPSDT Dentally Appropriate) as described in OAR chapter 410, division 151.¶
(2) Providers of OHP dental/denturist services and items must: ¶
(a) Be licensed to practice dentistry and enrolled as a Medicaid provider as required by OAR 410-120-1260; ¶
(b) Comply with ~~C~~chapter 410 Oregon Administrative Rules (OARs) applicable to their respective scopes of practice. Compliance with applicable ~~C~~chapter 410 rules does not precede compliance with any other state, local, or federal laws that may be applicable to their scopes of practice and business including, without limitation, licensing by the applicable licensing board of business licenses; and ¶
(c) Comply with ~~C~~chapter 410, ~~D~~division 120 Medical Assistance Program rules and the rules included in ~~C~~chapter 410, ~~D~~division 123 Dental/Denturist Services which identify the requirements for providing and submitting claims for dental services. ¶
(3) This rule incorporates ~~by this reference the Oregon Health Evidence Review Commission (HERC)~~the Oregon Health Authority Prioritized List of Health Services (OHA Prioritized List)~~, through the stated Funding Line (unless otherwise excluded in rule),~~ and including all line items, diagnostic and treatment codes, guideline notes, statements of intent, coding specifications and annotations (refer to OAR 410-141-3830) Providers must comply with the Authority rules for dental services covered by the OHP which include the: ¶
(a) ~~Funded~~ Lines on the OHA Prioritized List as defined in OAR 410-141-3830 found at www.oregon.gov/oha/hpa/dsi-herc/pages/prioritized-list.aspx; ~~and~~ ¶
(b) Approved ancillary procedure codes found at data.oregon.gov/Health-Human-Services/Group-6060-Ancillary-Services/fq2m-i6ix/about_data~~.~~; and¶
(4) Information for supplemental guidance only and not to be used for benefit coverage determination includes the following: ¶
(a) Oregon Medicaid Dental Services procedure code supplemental reference at https://data.oregon.gov/Health-Human-Services/Oregon-Medicaid-Dental-Services/495m-gmu2/about_data; ¶
(b) Medical-Dental Fee Schedule found on the OHP Fee-for-Service Fee Schedule site at www.oregon.gov/oha/hsd/ohp/pages/fee-schedule.aspx; and ¶
(c) American Dental Association (ADA)'s Current Dental Terminology (CDT) code book. The Authority does not cover all codes in the CDT code book. ¶
(5) The providers rendering services and receiving payment for any of the services identified in these ~~C~~chapter 410, ~~D~~division 123 rules must make records available for audit, as required by OAR 410-123-1620.¶
(6)~~ Providers of OHP dental/denturist services and items must comply with Chapter 410 Oregon Administrative Rules (OARs) applicable to their respective scopes of practice. Compliance with the applicable Chapter 410 rules does not precede compliance with any other state, local, or federal laws that may be applicable to their scopes of practice and businesses including, without limitation, licensing by the applicable licensing board of business licenses. ¶~~
~~(7) All coverage limitations and exclusions for services provided to OHP Members who meet the eligibility criteria for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) will be determined in accordance with criteria set forth in Chapter 410, Division 151, which requires case-by-case review for EPSDT Medical Necessity and~~

~~Dental Appropriateness.~~ ¶
~~(8)~~ Covered dental and oral health services provided in non-dental settings including medical, community and school settings by ~~providers who are medic~~ non-dental providers such as physicians and nurses~~. Criteria and limitations are as follows:~~¶
~~(a) Dental Screening of a patient (D0190) - including state or federally mandated screenings, are limited observations performed as mass screenings or EPSDT well-child and preventative care visits, to identify individuals who have suspected oral health needs and who must be seen by a dentist for diagnosis. Providers must hold~~ who have a certificate of completion of the Smiles for Life or First Tooth training~~; and~~re:¶
(~~b~~a) Dental Assessments (D0191) - do not take the place of dental evaluations or examinations. They are limited clinical inspections performed to identify possible signs of oral systemic disease, malformation, or injury, and the potential need for referral diagnosis and treatment. ~~Providers must hold a certificate of comple~~The assessment tool must be endorsed by the American Dental Associati~~on of,~~ the ~~Smile for Life or First Tooth training; ¶~~
~~(c) Application of topical fluoride (99128, 99188, D1206, D1208), requires providers to hold a certificate of completion of the Smiles for Life or First Tooth training;¶~~
~~(A) The application of topical fluoride may be delegated by providers to staff, in accordance to their professional boards' scope of pract~~American Academy of Pediatric Dentistry, the Association of the State and Territorial Dental Directors, or the American Academy of Pediatri~~c~~s;¶
(~~B~~A) For EPSDT beneficiaries - ~~limited to t~~Twice (2) every 12 months;¶
(~~C~~B) For non-EPSDT beneficiaries - ~~limited to o~~Once (1) every 12 months;¶
(~~D~~C) ~~Additional applications may be available, up to a total of four (4) per member within a 12 month period, when high-risk conditions or dental health factors are clearly document~~Reimbursable only if an exam (D0120-D0180) is not performed ~~i~~on ~~chart notes for members who:¶~~
~~(i) Have high-risk dental conditions due to disease process, medications, other medical treatments or conditions, or rampant caries; ¶~~
~~(ii) Are pregnant or 12 months postpartum;¶~~
~~(iii) Have physical disabilities and cannot perform adequate daily dental health care;¶~~
~~(iv) Have developmental disabilities or other severe cognitive impairment and cannot perform adequate daily dental health care; or¶~~
~~(v) Are under seven (7) years old with high-risk dental health factors, such as poor~~the same date of service at the same place of service;¶
(D) Referrals for identified dental needs or for the establishment of a dental home are to be made to the member's primary care dentist for FFS members, or to the member's CCO (or dental subcontractor); and¶
(E) Anticipatory guidance and counseling on good dental hygiene~~, deep pits and fissures in teeth, severely crow~~ practices and nutrition is to be provided t~~eeth, poor diet, etc.~~o the member or member's caregiver.¶
(~~d~~b) ~~A~~The application of ~~silver diamine fluoride (0792T) by a physician or o~~topical fluoride (99128, 99188, D1206, D1208) may be delegated to providers to their ~~healthcare professional is a covered benefit when the member has non-cavitated caries. Providers must hold a certificate of completion of the Smiles for Life or First Tooth training; ¶~~
~~(A) For all members - limited to two (2) applications per 12 months; and¶~~
~~(B) D~~staff in accordance to their professional boards' scope of practice. Limitations are defined in Section 8; and¶
(c) Application of silver diamine fluoride (0792T) is in accordance with the OHA Prioritized List Guideline Note 91. The documentation of need must be included on submitted claims. Limitations are defined in Section 8.¶
(~~9~~7) Diagnostic services (CDT codes D0100 - D0999):¶
(a) Dental screenings (D0190) a~~nd dental assessments (D0191),~~re pre-diagnostic and do not take the place of the need for c~~omprehensive dent~~linical oral evaluations and exams~~;¶~~
~~(A) For EPSDT beneficiaries - a maximum of twice (2) every 12 months; ¶~~
~~(B) For non-~~. Coverage is for EPSDT beneficiaries - ~~a maximum of on~~Twice (~~1~~2) every 12 months; ~~¶~~
~~(C) Reimbursable only if an exam (D0120-D0180) is not performed on the same date of service at the same place of service;¶~~
~~(D) The assessment tool used for D0190 and D0191 must be endorsed by the American Dental Association, the American Academy of Pediatric Dentistry, the Association of State and Territorial Dental Directors, or the American Academy of Pediatrics;¶~~
~~(E~~¶
(A) Referrals for identified dental needs or for the establishment of a dental home are to be made to the member's primary care dentist for FFS members, or to the member's CCO (or dental subcontractor); and¶
(~~F~~B) Anticipatory guidance and counseling on good dental hygiene practices and nutrition is to be provided to the member or member's caregiver.¶
(b) The Authority requires dental subcontractors and dental providers to conduct an intake screening of individuals who are enrolled in the Veterans Dental Program within 60 days of the enrolled individual contacting the dental subcontractor or dental provider. This intake screening requires one of the following services being provided, as

clinically appropriate:¶
(A) D0150 - comprehensive oral evaluation of a new or established patient;¶
(B) D0180 - comprehensive periodontal evaluation of a new or established patient; or¶
(C) D0120 - periodic oral evaluation of an established patient, if the individual enrolled in the Veterans Dental Program is an established patient. ¶
(c) Caries risk assessment and documentation (D0601, D0602, D0603) are not separately reimbursable but should be documented in the member's chart.¶
(d) Referrals:¶
(A) If, during the ~~screening~~oral evaluation process (periodic or inter-periodic), a dental, medical, substance abuse, or medical condition is discovered, the member must be referred to an appropriate provider for further diagnosis and/or treatment;¶
(B) The ~~screening provider~~provider who performed the oral evaluation must explain the need for the referral to the member, member's parent, or guardian;¶
(C) If the member, member's parent, or guardian agrees to the referral, assistance in finding an appropriate provider and making an appointment shall be offered; and¶
(D) The member's FFS provider or the CCO shall make available care coordination as needed.¶
(e) Clinical ~~D~~dental evaluations (~~E~~exams) for:¶
(A) EPSDT beneficiaries (refer to Division 151):¶
(i) The Authority covers exams (D0120, D0145, D0150, or D0180) ~~a maximum of~~ twice (2) every 12 months. These codes are not billable if D0191 is billed for the same date of service, at the same place of service. Limitations are as follows:~~-~~¶
(I) D0150: once (1) every 12 months when performed by the same practitioner;¶
(II) D0180: once (1) every 12 months; and¶
(ii) The Authority must reimburse D0160 only once (1) every 12 months when performed by the same practitioner.¶
(B) Non-EPSDT beneficiaries, the Authority covers exams (D0120, D0150, D0160, or D0180) once (1) every 12 months;¶
(C) For limited oral evaluation - problem-focused exams ~~(~~, including urgent or emergent problems~~)~~, the Authority covers D0140 for the initial exam and D0170 for related problem-focused follow-up exams. D0140 and D0170 are not covered for routine dental visits. Documentation should explain in detail the problem;¶
(D) The Authority only covers dental exams performed by ~~medical practitioners~~an Oregon licensed physician (or MD if ODs are precluded) only when the ~~medical practitioner is an oral surgeon~~physician (or MD) is also certified to practice an oral surgery by the Oregon Board of Dentistry. The surgeon may hold a dual degree, but must bill as an oral surgeon;¶
(E) The evaluation, diagnosis, and treatment planning components of the exam are the responsibility of the licensed provider. The Authority may not reimburse dental exams when performed by a dental hygienist (with or without an expanded practice permit).¶
(f) ~~The Authority covers diagnostic imaging as follows:~~Diagnostic imaging coverage is as follows:¶
(A) Members must be a minimum of six (6) years old for billing intra-oral complete series. The minimum standards for reimbursement of intra-oral complete series are:¶
(i) For members ages six (6) through 11 a minimum of 10 periapical and two (2) bitewings for a total of 12 films; and¶
(ii) For members ages 12 and older a minimum of 10 periapical and four (4) bitewings for a total of 14 films.¶
(~~A~~B) Intraoral - complete series (D0210) - One (1) time every five (5) years, unless D0330 has been billed within the five (5) year period;¶
(~~B~~C) Intraoral - first image (D0220) - One (1) time every 12 months;~~-~~¶
(~~C~~D) Intraoral - additional images (D0230)~~–~~ Under age six (6),~~-maximum of~~ five (5) times every 12 months. Not to exceed five (5) times on the same date of service for any provider~~.~~ Radiographs may be billed separately one (1) time every 12 months;¶
(~~D~~E) Intraoral - occlusal image (D0240) - One (1) time every 12 months. Not to exceed four (4) times on the same date of services for any provider; ¶
(~~E~~F) Extraoral images (D0250 and D0251) - One (1) time every 12 months;¶
(~~F~~G) Bitewing single image (D0270) - ~~Maximum of~~ two (2) times every 12 months if not billing D0272;~~-~~¶
(~~G~~H) Bitewing two images (D0272) - Under age six (6),~~-maximum of~~ one (1) time every 12 months if not billing D0270 twice;¶
(~~H~~I) Bitewing, multiple images (D0273, D0274 and D0277) - One (1) time every 12 months;¶
~~(I) Other TMJ images (D0321) - By Report; ¶~~
(J) Dental tomographic survey (D0322) - One (1) time every 12 months;¶
(K) ~~Panoramic image (D0330) - One (1) time every five (5) years, unless D0210 has been billed~~The Authority covers

panoramic image (D0330, D0701) or intra-oral complete series (D0210) once (1) every five (5) years. only one of these services can be done within the five (5) year period;¶
(L) Cone beam CT capture (D0364, D0365, D0366, D0367) - ~~Only when performed as part of the pre-orthodontic treatment examination; and~~¶
~~(M) 3d print of 3d surface scan (D0396).~~¶
~~(g) The Authority covers panoramic radiographic image (D0330) or intra-oral complete series (D0210) once (1) every five (5) years, but both cannot be done within the five (5) year period;~~¶
~~(h) Members must be a minimum of six (6) years old for billing intra-oral complete series. The minimum standards for reimbursement of intra-oral complete series are:~~¶
~~(A) For members age six (6) through 11 a minimum of 10 periapical and two (2) bitewings for a total of 12 films; and~~¶
~~(B) For members ages 12 and older a minimum of 10 periapical and four (4) bitewings for a total of 14 films~~EPSDT beneficiaries only as follows:¶
(i) For documentation and reporting only when performed as part of the pre-orthodontic treatment examination (D8660); and¶
(ii) Reimbursable when performed for surgical planning for repair of craniofacial anomalies and handicapping malocclusions, when Guideline Note 254 criteria is met.¶
(~~i~~M) If ~~fees~~the reimbursement for multiple single radiographs exceed the allowable reimbursement for an intraoral-complete series (full mouth), the Authority must reimburse for the complete series;¶
(~~j~~N) Additional films are covered if medically necessary and dentally appropriate (e.g., fractures);¶
(~~k~~O) If the Authority determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area shall be denied;¶
(~~l~~P) The exception to these limitations is if the member is new to the dental 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 must be included in the member's records; and¶
(~~m~~Q) Digital radiographs, if printed, must be on photo paper to assure sufficient diagnostic quality of images.¶
~~(10) Preventative Services (CDT codes D1000-D1999):~~¶
~~(a) Topical application of fluoride (D1206, D1208, 99128, 99188):~~¶
~~(A) For EPSDT beneficiaries, limited to twice (2) every 12 months;~~¶
~~(B) For non-EPSDT beneficiaries, limited to once (1) every 12 months;~~¶
~~(C) Additional topical fluoride treatments are available, up to a total of four (4) treatments per member within a 12 month period, when high-risk conditions or dental health factors are clearly documented by D0603 in chart notes for members who:~~¶
~~(i) Have high-risk dental conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;~~¶
~~(ii) Are pregnant or 12 months postpartum; ~~¶
~~(iii) Have physical disabilities and cannot perform adequate daily dental health care;~~¶
~~(iv) Have developmental disabilities or other severe cognitive impairment and cannot perform adequate daily dental health care; or~~¶
~~(v) Are under seven (7) years old with high-risk dental health factors, such as poor dental hygiene, deep pits, and fissures in teeth, severely crowded teeth, poor diet, etc.~~¶
~~(D) Fluoride limits include any combination of fluoride varnish or other topical fluoride.~~¶
~~(b) Dental sealants (D1351) are covered for EPSDT beneficiaries as follows:~~¶
~~(A) Members age 16 and older require PA; ~~¶
~~(B) Only permanent molars (additional teeth require PA); ~~¶
~~(C) Only one (1) sealant treatment per tooth every five (5) years, except when visible evidence of clinical failure; and~~¶
~~(D) The original provider is responsible for any repair or replacement during the 36-month period of initial sealant placement.~~¶
~~(c) Dental prophylaxis (D1110, D1120) are not covered by the Authority if provided on the same date of service as D4355, D4346 or D4910. Coverage is as follows:~~¶
~~(A) EPSDT beneficiaries, limited to twice (2) per 12 months;~~¶
~~(B) Non-EPSDT beneficiaries, limited to once (1) per 12 months; and~~¶
~~(C) Additional prophylaxis benefit provisions are available for persons with high-risk dental conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily dental health care.~~¶
~~(d) Silver diamine fluoride (SDF) application (D1354, D1355):~~¶
~~(A) Is covered for all members; ~~¶
~~(B) The Authority reimburses per application, not per tooth;~~¶

~~(C) Is limited to two (2) applications per year. Additional applications for EPSDT beneficiaries is allowable with approved PA;¶~~
~~(D) Requires that the tooth or teeth numbers be included on the claim;¶~~
~~(E) Use D1354 when SDF is applied for the treatment (rather than prevention) of caries. The treated tooth or teeth must be; ¶~~
~~(i) Covered with topical application of fluoride; or¶~~
~~(ii) Covered with an interim direct restoration (D2940) or a permanent restoration when medically necessary and dentally appropriate.¶~~
~~(F) When SDF is applied for the treatment of caries by a non-dental professional (0792T), refer to the guidance in the earlier section of this rule. Coverage is limited to two (2) applications per year. ¶~~
~~(e) Immunization counseling (D1301) is covered as described in 410-123-1262. ¶~~
~~(f) The Authority covers Tobacco counseling for the control and prevention of oral disease (D1320) for services provided during a dental visit, when using the Five-A approach outlined below, limited to a maximum of 10 services within a three (3) month period, when the following is provided:¶~~
~~(A) ASK: Identify the member's tobacco-use status at each visit and record information in the chart;¶~~
~~(B) ADVISE: Using a strong personalized message, advise members on their dental health conditions related to tobacco use and give direct advice to quit using tobacco and seek help;¶~~
~~(C) ASSESS: Refer member to external resources or internal counseling and intervention protocol if the tobacco user is willing to make a quit attempt;¶~~
~~(D) ASSIST: Provide counseling and pharmacotherapy to help member quit tobacco, if dental provider chooses to assist; and¶~~
~~(E) ARRANGE: Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date if dental provider chooses to arrange.¶~~
~~(g) The Authority covers Nutritional counseling (D1310) and Counseling for high risk substance use (D1321) for services provided during a dental visit using the Five-A approach outlined below. Each of these services is limited to two (2) services within a 12 month period, when the following is provided:¶~~
~~(A) ASK: Identify the member's behavior;¶~~
~~(B) ADVISE: Urge the member to change behavior;¶~~
~~(C) ASSESS: Determine the member's willingness to make change; ¶~~
~~(D) ASSIST: Help the member with a plan and resources, if dental provider chooses; and¶~~
~~(E) ARRANGE: Schedule follow-up support, if dental provider chooses. ¶~~
~~(h) Space maintenance (passive appliances) are:¶~~
~~(A) Covered for EPSDT beneficiaries; and¶~~
~~(B) Not replaceable when lost or damaged.¶~~
~~(11) The Authority's coverage limitations of restorative, periodontic, and prosthetic treatments include the following:¶~~
~~(a) Documentation must be included in the member's charts to support the treatment;¶~~
~~(b) Treatments must be consistent with the prevailing standard of care and may be limited as follows, when:¶~~
~~(A) Prognosis is unfavorable;¶~~
~~(B) Treatment is impractical;¶~~
~~(C) A lesser cost procedure achieves the same ultimate result; or ¶~~
~~(D) The treatment has specific limitations outlines in this rule. ¶~~
~~(c) Periodontal health needs to be stable and supportive of a prosthetic. Prosthetic treatment, including porcelain fused to metal crowns and porcelain/ceramic crowns are limited until documented by examination; ¶~~
~~(A) Rampant caries is arrested; and ¶~~
~~(B) A period of adequate dental hygiene and periodontal stability is demonstrated. ¶~~
~~(12) Restorative Services (CDT codes D2000-D2999):¶~~
~~(a) Amalgam and resin-based composite restorations, direct:¶~~
~~(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for EPSDT beneficiaries, and members who are pregnant;¶~~
~~(B) The Authority reimburses posterior composite restorations at the same rate as amalgam restorations;¶~~
~~(C) The Authority limits payment of posterior composite restorations to once (1) every five (5) years, per tooth;¶~~
~~(D) The Authority limits payment of covered restorations to the maximum restoration fee of four (4) surfaces per tooth. Refer to the 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 (4) or more surfaces);¶~~
~~(F) The Authority shall not reimburse for an amalgam or composite restoration and a crown on the same tooth;¶~~

(G) Interim direct restorations (D2940) on primary dentition are covered to restore and prevent progression of dental caries. They are not definitive restorations and are not to be used as a base or liner under a restoration;¶
(H) Reattachment of tooth fragment is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment;¶
(I) The Authority reimburses for a surface not more than once (1) in each treatment episode regardless of the number or combination of restorations; and¶
(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration.¶
(b) Indirect crowns and related services:¶
(A) The fee for the crown includes payment for preparation of the gingival tissue;¶
(B) The Authority covers crowns only when there is significant loss of clinical crown, no other restorations restore function, the crown-to-root ratio is 50:50 or better, and the tooth is restorable to function without other surgical procedures. Endodontic therapy alone (with or without a post) is not a consideration, nor are aesthetics;¶
(C) The Authority covers core buildup only when: ¶
(i) Necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture; ¶
(ii) Done in conjunction with a crown; and¶
(iii) More than 50 percent of the tooth structure is remaining for coverage of the core buildup.¶
(D) Reimbursement of retention pins is per tooth, not per pin;¶
(E) Payment shall be made only upon final cementation; ¶
(F) Partial payment will not be made for an undelivered crown; ¶
(G) Prefabricated stainless steel crowns are allowed only for anterior primary teeth and posterior permanent or primary teeth;¶
(H) The Authority covers the following only for EPSDT beneficiaries, and for members who are pregnant:¶
(i) Prefabricated resin crowns for anterior teeth, permanent or primary;¶
(ii) Prefabricated resin crowns for posterior teeth, permanent or primary, once (1) per tooth in a five (5) year period;¶
(iii) Prefabricated stainless-steel crowns with resin window are allowed only for anterior teeth, permanent or primary;¶
(iv) Prefabricated post and core in addition to crowns;¶
(v) Crowns (resin-based composite - D2710 and D2712, porcelain fused to metal (PFM) - D2751 and D2752, and porcelain ceramic - D2740 as follows:¶
(I) Limited to teeth numbers 6-11, 22, and 27 only, if dentally appropriate;¶
(II) Limited to four (4) in a seven (7) year period. This limitation includes any replacement crowns allowed; and¶
(III) Rampant caries are arrested, and the member demonstrates a period of adequate dental hygiene before prosthetics are proposed.¶
(vi) Porcelain fused to metal crowns (D2751, D2752), and porcelain ceramic crowns (D2740) must 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 member's chart indicates that PFM is the only restoration option that restores function;¶
(III) The Dental Practitioner submits radiographs to the Authority for review. History, diagnosis, and treatment plan may be requested;¶
(IV) The member has documented stable periodontal status with clinical attachment loss within 1-3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeters and over, documentation must be maintained in the member's chart of the dentist's findings supporting stability and why the increased pocket depths shall 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 must have favorable expected long-term prognosis.¶
(I) Crown replacement coverage is as follows:¶
(i) D2710, D2712, D2740, D2751, D2752 are limited to once (1) every seven (7) years;¶
(ii) All other covered crowns are limited to once (1) every five (5) years; and¶
(iii) Exceptions to the above limitations due to acute trauma are 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 may result in coverage of removable prosthetic.¶
(J) Crown repair requires PA and is limited to anterior teeth.¶

(13) Endodontic Services (CDT codes D3000-D3999):¶
(a) All radiographic images taken during the course of root canal therapy and all post-treatment radiographic images are included in the fee for the root canal procedure. At least one (1) pre-treatment radiographic image demonstrating the need for the procedure, and one (1) post-treatment radiographic images that demonstrates the result of the treatment, must be maintained in the member's record; ¶
(b) The Authority covers endodontic therapy as follows only when the crown-to-root ration is 50:50 or better and if the tooth is restorable to function with direct or indirect restoration without other surgical procedures:¶
(A) For EPSDT beneficiaries: all primary teeth, permanent anterior teeth, premolars, first molars and second molars;¶
(B) For members who are pregnant or 12 months postpartum: permanent anterior teeth, premolars, and first molars; and¶
(C) For non-pregnant adults: anterior teeth and premolars. ¶
(c) Endodontic retreatment and apicoectomy:¶
(A) The Authority does not cover retreatment of a previous root canal or apicoectomy for premolars or molars;¶
(B) The Authority 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 shall result in the need for removable prosthodontics.¶
(C) Retrograde filling is covered only when done in conjunction with a covered apicoectomy of an anterior tooth.¶
(d) The Authority 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) Apexification/recalcification procedures:¶
(A) The Authority limits payment for apexification to permanent teeth only;¶
(B) D3351-D3353 are limited to once (1) per tooth; and¶
(C) Covered only for EPSDT beneficiaries, or members who are pregnant or 12 months postpartum.¶
(14) Periodontic Services (CDT codes D4000-D4999):¶
(a) The Authority does not reimburse the following codes if performed on the same date of service D1110, D1120, D4210, D4211, D4341, D4346, D4355, and D4910.¶
(b) Surgical periodontal services:¶
(A) Gingivectomy/Gingivoplasty (D4210, D4211) coverage is limited to severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to dental hygiene procedures (e.g., Dilantin hyperplasia), and includes six (6) months routine postoperative care; and¶
(B) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) is considered part of the restoration and is not separately billable. ¶
(c) Non-surgical periodontal services:¶
(A) Periodontal scaling and root planing (D4341, D4342) is allowed once (1) every two (2) years;¶
(i) A maximum of two (2) quadrants on one date of service is payable, except in extraordinary circumstances supported by documentation;¶
(ii) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets of 5 mm or greater:¶
(B) Single implants may count as an additional tooth when billing, the maximum number per quadrant and pocket depth requirements still apply;¶
(C) Full mouth debridement (D4355) allowed once (1) every two (2) years; and¶
(D) Scaling in the presence of generalized moderate or severe gingival inflammation, full mouth, after dental evaluation (D4346) is allowed once (1) every two (2) years.¶
(d) Periodontal maintenance (D4910) is allowed once (1) every six (6) months:¶
(A) Following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three (3) years; and¶
(B) Additional periodontal maintenance requires PA and may be requested when:¶
(i) Medically necessary and dentally appropriate, including situations involving periodontal disease during pregnancy; and¶
(ii) The member's medical record is submitted and supports the need for increased periodontal maintenance (chart notes, pocket depths and radiographs).¶
(e) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and radiographs;¶
(15) Prosthodontics, Removable (CDT codes D5000-D5899):¶
(a) The Authority covers complete dentures once (1) every 10 years, only if medically necessary and dentally

~~appropriate, with PA approval;¶~~
~~(A) Coverage is for only one of the following options (not both);¶~~
~~(i) Complete dentures (D5110, D5120); or¶~~
~~(ii) Immediate dentures (D5130, D5140);¶~~
~~(B) The Authority's 10-year coverage limitation for complete dentures applies regardless of the member's OHP or CCO enrollment status at the time the member received the denture; and¶~~
~~(C) The member's periodontal health needs to be stable and supportive of a prosthetic.¶~~
~~(b) The fee for the denture includes payment for adjustments during the six (6) month period following the delivery of the denture. Adjustments and repairs needed beyond six (6) months from the delivery of the denture are covered by the Authority as follows:¶~~
~~(A) A maximum of four (4) times per year for:¶~~
~~(i) Adjustments to dentures, per arch (D5410, D5411);¶~~
~~(ii) Replacement of missing or broken teeth, each tooth (D5520); and¶~~
~~(B) A maximum of two (2) times per year for broken complete denture base (D5511, D5512).¶~~
~~(c) The Authority covers partial dentures once (1) every five (5) years, only if medically necessary and dentally appropriate, with PA approval; ¶~~
~~(A) Coverage is for only one of the following options:¶~~
~~(i) Partial denture resin base (D5211, D5212);¶~~
~~(ii) Immediate partial denture (D5221, D5222) or¶~~
~~(iii) Interim partial dentures (D5820, D5821); ¶~~
~~(B) The Authority's five (5) year coverage limitation for partial dentures applies regardless of the member's OHP or CCO enrollment status at the time the member's last partial was received;¶~~
~~(C) Periodontal health needs to be stable and supportive of a prosthetic; ¶~~
~~(D) Interim partial dentures (also referred to as "flippers") are covered only if the member has one (1) or more anterior teeth missing;¶~~
~~(E) Partial dentures and immediate partial dentures are covered as follows: ¶~~
~~(i) For EPSDT members: The member must have one (1) or more anterior teeth missing or four (4) or more missing posterior teeth per arch with resulting space equivalent to the loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;¶~~
~~(ii) For non-EPSDT members: The member must have one (1) or more missing anterior teeth or six (6) 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;¶~~
~~(F) The Practitioner must note the teeth to be replaced and the teeth to be clasped with requesting PA; ¶~~
~~(G) The Authority does not approve resin partial dentures (D5211, D5212) if stainless steel crowns are used as abutments; and¶~~
~~(H) Partial dentures are not to be used in lieu of space maintainers. ¶~~
~~(d) The fee for the partial denture includes payment for adjustments during the six (6) month period following delivery. Adjustments and repairs needed beyond six (6) months after delivery of the partial denture as follows:¶~~
~~(A) A maximum of four (4) times per year for:¶~~
~~(i) Adjustments to partial dentures, per arch (D5421, D5422)¶~~
~~(ii) Replace broken tooth on a partial denture, each tooth (D5640)¶~~
~~(iii) Add tooth to existing partial denture (D5650);¶~~
~~(B) A maximum of two (2) times per year for:¶~~
~~(i) Repair resin partial denture base (D5611, D5612);¶~~
~~(ii) Repair cast partial framework (D5621, D5622); ¶~~
~~(iii) Repair or replace broken retentive/clasping materials, per tooth (D5630); and¶~~
~~(iv) Add clasp to existing partial denture, per tooth (D5660);¶~~
~~(C) Replacement of all partial denture teeth and acrylic on cast metal framework (D5670, D5671), with PA approval;¶~~
~~(i) A maximum of once (1) per five (5) years per arch;¶~~
~~(ii) When five (5) or more years have passed since the partial denture was originally delivered; and¶~~
~~(iii) Is considered replacement of the partial denture so a new denture shall not be reimbursed for another five (5) years.¶~~
~~(e) For denture reimbursement;¶~~
~~(A) The member must have active coverage on the date of the final impression;¶~~
~~(B) The dentures must be delivered within 45 days of the date of the final impression; and¶~~
~~(C) The claim includes both the date of the final impression and the date of delivery. If the member loses OHP coverage during the time that the denture is being fabricated, submit the claim using the date of the final impression.¶~~

(f) The Authority may cover reasonable and necessary replacement of medically necessary and dentally appropriate covered dentures, including those purchased or in used before the member enrolled with OHP;¶
(g) Replacement of dentures is covered involving the provision of the medically necessary and dentally appropriate item when:¶
(A) The item cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement);¶
(B) The loss of the item is due to circumstance beyond the member's control (e.g., irreparable damage referring to a specific accident, natural disaster, or situation); ¶
(C) There is a change in the member's condition that warrants a new item (e.g., cases of acute trauma, catastrophic illness that directly or indirectly affects the dental condition and results in additional tooth loss). This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for conditions mentioned earlier; and ¶
(D) There is coverage for the specific item as identified in Chapter 410, Division 123.¶
(h) The Authority may not cover replacement of dentures:¶
(A) When cases suggest malicious damage, culpable neglect, or wrongful disposition of the denture; or ¶
(B) In the presence of untreated severe periodontal disease.¶
(i) Replacement of a partial denture with a complete denture is payable five (5) years after the partial denture placement; ¶
(j) The Authority covers denture rebase procedures (D5710, D5711, D5720, D5721) as follows, only if a reline does not adequately solve the problem:¶
(A) For EPSDT members: once (1) every three (3) years;¶
(B) For non-EPSDT members: once (1) every five (5) years when there is documentation of a current, failed reline procedure;¶
(C) Exceptions to these limitations may be considered by the Authority for conditions as listed for warranting replacement of partial and complete dentures; and¶
(D) Untreated severe periodontal disease may not warrant rebase procedures.¶
(k) The Authority covers denture reline (direct) procedures (D5730, D5731, D5740, D5741) as follows: ¶
(A) For EPSDT members: once (1) every three (3) years;¶
(B) For non-EPSDT members: once (1) every five (5) years;¶
(C) A new or replacement complete or partial denture(s) on the same arch are not reimbursable for 12 months after the reline; and¶
(D) Exceptions to these limitations may be considered by the Authority for conditions as listed for warranting replacement of partial and complete dentures.¶
(l) The Authority covers denture reline (indirect) laboratory procedures (D5750, D5751, D5760, D5761) six (6) months after placement of any denture as follows:¶
(A) For EPSDT members: once (1) every three (3) years;¶
(B) For non-EPSDT members: once (1) every five (5) years; ¶
(C) A new or replacement denture on the same arch is not reimbursable for 12 months after the reline; and¶
(D) Exceptions to these limitations may be considered by the Authority for conditions as listed for warranting replacement of partial and complete dentures.¶
(m) The Authority covers tissue conditioning (D5850, D5851) for all members once:¶
(A) Per denture unit in conjunction with immediate dentures; and ¶
(B) Prior to new denture placement. ¶
(16) Maxillofacial Prosthetic Services (CDT codes D5900-D5999):¶
(a) Fluoride gel carrier is limited to those members whose severity of dental 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; and¶
(b) All other maxillofacial prosthetics are medical services;¶
(A) Bill for medical maxillofacial prosthetics using the professional (CMS1500, DMAP 505, 837D or 837P) claim format;¶
(B) For members receiving services through a CCO, bill medical maxillofacial prosthetics to the CCO; and¶
(C) For members receiving medical services through FFS, bill the Authority.¶
(17) Prosthodontics, Fixed (CDT codes D6200-D6999): Surgical removal of implant body (D6100) and Removal of implant body (D6105) are covered for all members, per Guideline Note 123, when there is:¶
(a) Advanced peri-implantitis with bone loss and mobility, abscess; or ¶
(b) Implant fracture.¶
(18) Oral & Maxillofacial Surgery (D7000-D7999): Billing Procedures:¶
(a) Bill on a dental claim form using CDT codes for procedures that are directly related to the teeth and the structures directly supporting teeth;¶

(b) The Medical/Surgical Program is responsible for all dental health procedures performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, roof of mouth). Such procedures must be billed using ICD-10, HCPCS and CPT billing codes using the professional (CMS1500, DMAP 505 or 837P) claim format;¶
(c) The following services are covered based on severity and included situations deemed to cause gingival recession or movement of the gingival margin when frenum is placed under tension:¶
(A) Buccal/labial frenectomy (frenulectomy) (D7961), refer to Guideline Note 48;¶
(i) Maxillary labial frenulectomy is not covered until age 12; and¶
(ii) Not billable if member has received D7963; ¶
(B) Lingual frenectomy (frenulectomy) (D7962), refer to Guideline Note 48 and 139, is not covered until age 12 unless ankyloglossia is interfering with breastfeeding; or ¶
(C) Frenuloplasty (D7963), refer to Guideline Note 48; ¶
(i) Once (1) per lifetime per quadrant; and¶
(ii) Not billable if member has received D7961.¶
(d) Emergency tracheotomy (D7990) is an ancillary code reimbursable for all members;¶
(e) All ancillary and diagnosis codes must be used for services that are medically necessary and dentally appropriate; and¶
(f) Alveoloplasty not in conjunction with extractions (D7320, D7321) is reimbursable for EPSDT beneficiaries, and for members who are pregnant or 12 months postpartum. ¶
(19) Orthodontics (CDT Codes D8000-D8999):¶
(a) The Authority covers orthodontia services and extractions to treat cleft palate with airway obstruction, cleft palate and/or cleft lip, or deformities of the head, and handicapping malocclusions (HM), not for cosmetic purposes, when:¶
(A) The member has a craniofacial anomaly health condition that is included on a covered line of the Prioritized List of Health Services; ¶
(B) The Authority approves the PA request for orthodontic treatment: and¶
(C) EPSDT qualification for the OHP Orthodontic benefit is determined when;¶
(i) Dental Appropriateness as demonstrated when the member has a malocclusion; and ¶
(ii) Medical Necessity for the orthodontic treatment is demonstrated when the member meets the automatic qualifying criteria and/or a score of 26 or higher on the Handicapping Labiolingual Deviation (HLD) score index.¶
(b) Pre-orthodontic treatment examinations (D8660) must be provided by a licensed dentist.¶
(c) Pre-orthodontic treatment examinations (D8660) do not require PA. Coverage is for members whose clinical presentation and preliminary comprehensive or periodic exam findings strongly suggest that they may qualify for orthodontic treatment under HM criteria, as established by the Authority. The imaging required for evaluation is not to be billed separately. Coverage is:¶
(A) Once (1) per member, per provider, in a 12 month period (not on the same day as another routine or general dental evaluation or examination); and¶
(B) When submitted alongside the following documentation to justify the need for treatment:¶
(i) The Authority-approved HLD Index California Modified Scoring Form (completed, scored, and signed);¶
(ii) Intra-oral and extra-oral photographs of diagnostic quality, adhering to American Association of Orthodontists (AAO) standards, capturing key aspects of the malocclusion;¶
(iii) Panoramic radiographs or cephalometric images including tracings that document skeletal and dental relationships crucial for evaluating the severity of malocclusion; and¶
(iv) A comprehensive narrative of medical necessity, explicitly stating how the malocclusion significantly impacts the member's oral health, airway, or overall functional capacity.¶
(d) PA approval for comprehensive orthodontic treatment (D8070, D8080, D8090, D8091), must meet the criteria in Guideline Note 169 of the Prioritized List of Health Service.¶
(e) Comprehensive orthodontic treatment must be completed by a licensed dentist who has:¶
(A) Completed a Commission of Dental Accreditation (CODA) orthodontic fellowship or residency program;¶
(B) Certified additional orthodontic training, a minimum of 30 hours of orthodontic continuing education (CE) in the past three (3) years that was approved by the American Dental Association Continuing Education Recognition Program (ADA CERP); or¶
(C) Completed five (5) comprehensive orthodontic treatment cases in the past three (3) years, verified by case logs and patient outcomes.¶
(f) Orthodontic treatment must begin while the member is an EPSDT beneficiary, or immediately after, if surgical corrections that were started during the member's EPSDT beneficiary period for covered conditions were not completed during that period.¶
(g) Payment for comprehensive orthodontic treatment includes all appliances, repairs, and all follow-up visits.¶
(h) The Authority pays for orthodontia in one (1) lump sum upon beginning of treatment;¶

(A) If the member transfers to another orthodontist during treatment, or treatment is terminated, the Authority shall recover the overpayment (refer to OAR 410-120-1397) based on the length of the treatment plan from the first date of service (DOS); and ¶
(B) Providers may discontinue orthodontic treatment of a member in cases including poor dental hygiene, continued missed appointments, or if treatment is a detriment to the member.¶
(i) Licensed dentists providing orthodontic treatment may:¶
(A) Submit PA requests for the extractions and/or bond surgeries that are documented as needed in the member's orthodontic treatment plan; and¶
(B) Refer members to enrolled specialists for extractions and/or bond surgeries when such services are beyond the scope of the member's primary care dentist. ¶
(j) As long as the orthodontist continues treatment, the Authority may not require a refund even though the member may become ineligible for medical assistance sometime during the treatment period.¶
(k) Care navigation assistance for members must be made available during transfer of care in situations such as provider changes.¶
(20) Adjunctive General and Other Services (CDT codes D9000-D9999):¶
(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 and sedation:¶
(A) The Authority reimburses administration of general anesthesia or IV sedation only for those members with concurrent needs: age; physical, medical, or mental status; or degree of difficulty of the procedure; and¶
(B) The Authority reimburses providers with a current permit to administer General Anesthesia or IV Sedation as follows:¶
(i) For each 15-minute period, up to two and a half hours on the same day of service in a dental office setting, and up to three and a half hours on the same day of service in a hospital setting and ASC;¶
(ii) Each 15-minute period represents a quantity of one (1). Enter this number in the quantity column.¶
(C) The Authority reimburses administration of Nitrous Oxide per date of service, not by time;¶
(D) Enteral and Non-intravenous parenteral conscious sedation with or without coadministration of Nitrous Oxide are covered only for EPSDT beneficiaries as follows:¶
(i) Members age 13 and older require PA;¶
(ii) Limited to four (4) times per year; and¶
(iii) Includes payment for monitoring and Nitrous Oxide;¶
(E) Upon request, providers must submit a copy of their permit to administer Anesthesia, Analgesia, and Sedation to the Authority; and¶
(F) The Authority covers CPT 00170 (anesthesia services during procedures on the mouth). When billing for services provided in conjunction with dental treatments in the office setting, use the professional claim format using an appropriate non-facility Place of Service code.¶
(c) House/extended care facility call (D9410) is limited to 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's or facility's convenience.¶
(21) Sleep Apnea Services:¶
(a) Sleep apnea devices and appliances may be placed or fabricated by a general dentist or specialist although they are considered medical services;¶
(b) Bill for sleep apnea services using medical billing codes on the professional claim form unless guidance specifies otherwise;¶
(c) Custom sleep apnea appliance fabrication and placement (D9947) must be billed on a dental claim form (see HERC Guideline Notes 27 and 36 for criteria), and is replaceable at the end of the five (5) year reasonable useful lifetime;¶
(d) The Authority does not cover adjustments for dental sleep apnea appliances. The adjustments are considered part of the normal follow-up care within the first 90 days after provision of the device, and are included as services of (D9947); and¶
(e) Dental sleep apnea repairs (D9949) are covered when necessary and appropriate to make item serviceable. If the expense for repairs exceeds the estimated expense of purchasing another item, no payment must be made for the excess.¶
(22) Dental care access standards for pregnant members:¶
(a) Dental care benefits for pregnant members shall continue for 12 months following the end of pregnancy; and¶
(b) For additional dental care benefit for members who are pregnant or 12 months postpartum, refer to OAR 410-123-1510. ¶
(23) Services considered incidental, integral to the primary service rendered, part of another service, or included in

~~routine post-op or follow-up care are not eligible for separate reimbursement.¶~~
~~(a) Participating providers may not balance bill members for these services;¶~~
~~(b) Not all services included in the Current Dental Terminology (CDT) codebook are covered by the Authority; ¶~~
~~(c) These services must not be listed as combined with another procedure; and¶~~
~~(d) Under the Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS) issued regulations in 2024 for payment for dental services that are inextricably linked to certain covered medical services, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, valvuloplasty procedures, and treatments for head and neck cancers. Such services should be billed directly to Medicare.¶~~
~~(24) The following services are not eligible for separate reimbursement:¶~~
~~(a) Alveolectomy/Alveoloplasty in conjunction with extractions;¶~~
~~(b) Cardiac and other monitoring;¶~~
~~(c) Caries risk assessment and documentation (D0601-D0603);¶~~
~~(d) Curettage and root planing - per tooth is not eligible for separate reimbursement unless the service is significant and separately identifiable;¶~~
~~(e) Diagnostic casts (D0470);¶~~
~~(f) Direct pulp cap (D3110);¶~~
~~(g) Discing;¶~~
~~(h) Dressing change;¶~~
~~(i) Electrosurgery;¶~~
~~(j) Equilibration;¶~~
~~(k) Gingival curettage - per tooth (D4220);¶~~
~~(l) Gingival irrigation (D4921);¶~~
~~(m) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212);¶~~
~~(n) Indirect pulp cap (D3120);¶~~
~~(o) Local anesthesia;¶~~
~~(p) Medicated pulp chambers;¶~~
~~(q) Occlusal adjustments (D9951, D9952);¶~~
~~(r) Occlusal analysis;¶~~
~~(s) Odontoplasty;¶~~
~~(t) Oral hygiene instruction (D1330);¶~~
~~(u) Periodontal charting, probing;¶~~
~~(v) Post removal;¶~~
~~(w) Polishing fillings;¶~~
~~(x) Post extraction treatment for alveolaritis (dry socket treatment) if done by the provider of the extraction;¶~~
~~(y) Pulp vitality tests (D0460);¶~~
~~(z) Smooth broken tooth;¶~~
~~(aa) Special infection control procedures;¶~~
~~(bb) Surgical procedure for isolation of tooth with rubber dam (D3910);¶~~
~~(cc) Surgical splint (D5988);¶~~
~~(dd) Surgical stent (D5982); ¶~~
~~(ee) Suture removal; ¶~~
~~(ff) Testing for cracked tooth (D0461); and¶~~
~~(gg) Teledentistry (D9995, D9996).¶~~
~~(25) The following general categories of dental services are not covered for any member, unless coverage is specified or member is an EPSDT beneficiary and meets requirements of OAR Chapter 410, Division 151, as several of these services are considered elective or "cosmetic" in nature (i.e., done for the sake of appearance):¶~~
~~(a) Desensitization;¶~~
~~(b) Implant and implant services (See Prioritized List Guideline Notes 123 and 169);¶~~
~~(c) Mastique or veneer procedure;¶~~
~~(d) Orthodontic treatment;¶~~
~~(e) Overhang removal;¶~~
~~(f) Procedures, appliances, or restorations solely for aesthetic or cosmetic purposes;¶~~
~~(g) Temporomandibular joint (TMJ) dysfunction treatment; and¶~~
~~(h) Tooth bleaching.¶~~
~~(26) Current Dental Terminology, © 2025~~R) Radiographic interpretation only (D0391) is covered for improved access with the following conditions:¶
(i) Submitted claims must include a detailed interpretation report completed by a licensed dentist or oral and maxillofacial radiologist.¶

(ii) Image capture-only services must be performed within the provider's board-authorized scope of practice.¶
(iii)Image capture-only and interpretation-only codes are subject to the same clinical frequency limitations as standard comprehensive imaging codes.¶
(iv) Reimbursement applies to only one radiographic service set per encounter (either standard capture-plus-interpretation, or split capture and interpretation)-never duplicate or overlapping payments for the same image.¶
(8) Preventative Services (CDT codes D1000-D1999):¶
(a) Topical application of fluoride (D1206, D1208, 99128, 99188) limitations include any combination of fluoride varnish or other topical fluoride:¶
(A) For EPSDT beneficiaries -- twice (2) every 12 months;¶
(B) For non-EPSDT beneficiaries -- once (1) every 12 months;¶
(C) Additional topical fluoride treatments are available, up to a total of four (4) treatments per member within a 12-month period, when high-risk conditions or dental health factors are clearly documented by D0603 in chart notes for members who:¶
(i) Have high-risk dental conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;¶
(ii) Are pregnant or 12 months postpartum;¶
(iii) Have physical disabilities and cannot perform adequate daily dental health care;¶
(iv) Have developmental disabilities or other severe cognitive impairment and cannot perform adequate daily dental health care; or¶
(v) Are under seven (7) years old with high-risk dental health factors, such as poor dental hygiene, deep pits, and fissures in teeth, severely crowded teeth, poor diet, etc.¶
(b) Dental sealants (D1351) are covered for all EPSDT beneficiaries with the following limitations:¶
(A) Members age 16 and older require PA;¶
(B) Teeth other than permanent molars require PA;¶
(C) Only one (1) sealant treatment per tooth every five (5) years, except when visible evidence of clinical failure; and¶
(D) The original provider is responsible for any repair or replacement during the 36-month period of initial sealant placement.¶
(c) Dental prophylaxis (D1110, D1120) are not covered by the Authority if provided on the same date of service as D4355, D4346 or D4910. Coverage is as follows:¶
(A) For EPSDT beneficiaries -- twice (2) per 12 months;¶
(B) For Non-EPSDT beneficiaries-- once (1) per 12 months; and¶
(C) Additional treatments are available for persons with high-risk dental conditions due to disease process, pregnancy, medications, or other medical treatments or conditions, severe periodontal disease, rampant caries and for persons with disabilities who cannot perform adequate daily dental health care.¶
(d) Silver diamine fluoride (SDF) applications (D1354, D1355, 0792T) are covered for all members. The limitation of two (2) applications per year includes any combination of the listed codes. Coverage criteria is as follows:¶
(A) The Authority reimburses per application, not per tooth;¶
(B) Additional applications for EPSDT beneficiaries are allowable with approved PA;¶
(C) Tooth or teeth numbers must be included on the claims for D1354 and D1355;¶
(D) Use D1354 when SDF is applied for the treatment (rather than prevention) of caries. The treated tooth or teeth must be:¶
(i) Covered with topical application of fluoride; or¶
(ii) Covered with an interim direct restoration (D2940) or a permanent restoration when medically necessary and dentally appropriate.¶
(E) When SDF is applied for the treatment of caries by a non-dental professional (0792T), refer to the guidance in the earlier section of this rule.¶
(e) Immunization counseling (D1301) is covered as described in OAR 410-123-1262.¶
(f) The Authority covers Tobacco counseling for the control and prevention of oral disease (D1320) for services provided during a dental visit, when using the Five-A approach outlined below, limited to 10 services within a three (3) month period, when the following is provided:¶
(A) ASK: Identify member's tobacco-use status at each visit and record information in the chart;¶
(B) ADVISE: Using a strong personalized message, advise members on their dental health conditions related to tobacco use and give direct advice to quit using tobacco and seek help;¶
(C) ASSESS: Refer members to external resources or internal counseling and intervention protocol if the tobacco users are willing to make a quit attempt;¶
(D) ASSIST: Provide counseling and pharmacotherapy to help member quit tobacco, if dental provider chooses to assist; and¶
(E) ARRANGE: Schedule follow-up contact, in person or by telephone, preferably within the first week after the

quit date if dental provider chooses to arrange.¶
(g) The Authority covers Nutritional counseling (D1310) and Counseling for high risk substance use (D1321) as services provided during a dental visit using the Five-A approach outlined below. The frequency for these services is two (2) services within a 12- month period, when the following is provided:¶
(A) ASK: Identify the member's behavior;¶
(B) ADVISE: Urge the member to change behavior;¶
(C) ASSESS: Determine the member's willingness to make change; ¶
(D) ASSIST: Help the member with a plan and resources, if dental provider chooses; and¶
(E) ARRANGE: Schedule follow-up support, if dental provider chooses.¶
(h) Space maintenance (passive appliances) are:¶
(A) Covered for EPSDT beneficiaries; and¶
(B) Replaceable when lost or damaged requires PA.¶
(9) The Authority's coverage limitations of restorative, periodontic, and prosthetic treatments include the following:¶
(a) Documentation must be included in the member's charts to support the treatment;¶
(b) Treatments must be consistent with the prevailing standard of care and may be limited as follows, when:¶
(A) Prognosis is unfavorable;¶
(B) Treatment is impractical;¶
(C) A lesser cost procedure achieves the same ultimate result; or¶
(D) The treatment has specific limitations outlines in this rule. ¶
(c) Periodontal health needs to be stable and supportive of a prosthetic. Prosthetic treatment, including porcelain fused to metal crowns and porcelain/ceramic crowns are limited until documented by examination;¶
(A) Rampant caries is arrested; and¶
(B) A period of adequate dental hygiene and periodontal stability is demonstrated.¶
(10) Restorative Services (CDT codes D2000-D2999):¶
(a) Amalgam and resin-based composite restorations, direct:¶
(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for EPSDT beneficiaries, and members who are pregnant or up to 12 months postpartum;¶
(B) The Authority reimburses posterior composite restorations at the same rate as amalgam restorations;¶
(C) The Authority limits payment of posterior composite restorations to once (1) every five (5) years, per tooth;¶
(D) The Authority limits payment of covered restorations to the maximum restoration fee of four (4) surfaces per tooth. Refer to the 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 (4) or more surfaces);¶
(F) The Authority will not reimburse for an amalgam or composite restoration and a crown on the same tooth;¶
(G) Interim direct restorations (D2940) on primary dentition are covered to restore and prevent progression of dental caries. They are not definitive restorations and are not to be used as a base or liner under a restoration;¶
(H) Reattachment of tooth fragment is covered once in the lifetime of a tooth when there is no pulp exposure and no need for endodontic treatment;¶
(I) The Authority reimburses for a surface not more than once (1) in each treatment episode regardless of the number or combination of restorations; and¶
(J) The restoration fee includes payment for occlusal adjustment and polishing of the restoration.¶
(b) Indirect crowns and related services:¶
(A) The fee for the crown includes payment for preparation of the gingival tissue;¶
(B) The Authority covers crowns only when there is significant loss of clinical crown, no other restorations restore function, the crown-to-root ratio is 50:50 or better, and the tooth is restorable to function without other surgical procedures. Endodontic therapy alone (with or without a post) is not a consideration, nor are aesthetics;¶
(C) The Authority covers core buildup only when:¶
(i) Necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture;¶
(ii) Done in conjunction with a covered crown; and¶
(iii) More than 50 percent of the tooth structure is remaining for coverage of the core buildup.¶
(D) Reimbursement of retention pins is per tooth, not per pin;¶
(E) Payment shall be made only upon final cementation;¶
(F) Partial payment will not be made for an undelivered crown;¶
(G) The Authority covers prefabricated stainless steel crowns for all members; limited to anterior primary teeth; and posterior permanent or primary teeth;¶
(H) The Authority covers the following only for EPSDT beneficiaries, and for members who are pregnant and up to

12 months postpartum:¶
(i) Prefabricated resin crowns for anterior teeth, permanent or primary;¶
(ii) Prefabricated resin crowns for posterior teeth, permanent or primary;¶
(iii) Prefabricated stainless steel crowns with resin window are allowed only for anterior teeth, permanent or primary;¶
(iv) Prefabricated post and core in addition to crowns;¶
(v) Crowns (resin-based composite - D2710 and D2712, porcelain fused to metal (PFM) - D2751 and D2752, and porcelain ceramic - D2740 as follows:¶
(I) Limited to teeth numbers 6-11, 22, and 27 only, if dentally appropriate;¶
(II) Limited to four (4) in a seven (7) year period. This limitation includes any replacement crowns allowed; and¶
(III) Rampant caries are arrested, and the member demonstrates a period of adequate dental hygiene before prosthetics are proposed.¶
(vi) Porcelain fused to metal crowns (D2751, D2752), and porcelain ceramic crowns (D2740) must 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 member's chart indicates that a crown is the only restoration option that restores function;¶
(III) The Dental Practitioner submits radiographs to the Authority for review. History, diagnosis, and treatment plan may be requested;¶
(IV) The member has documented stable periodontal status with clinical attachment loss within 1-3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeters and over, documentation must be maintained in the member's chart of the dentist's findings supporting stability and why the increased pocket depths shall 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 must have favorable expected long-term prognosis.¶
(I) Crown replacement coverage is as follows:¶
(i) D2710, D2712, D2740, D2751, D2752 are limited to once (1) every seven (7) years;¶
(ii) All other covered crowns are limited to once (1) every five (5) years; and¶
(iii) Exceptions to the above limitations due to acute trauma are 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 may result in coverage of removable prosthetic.¶
(J) Crown repair requires PA and is limited to anterior teeth.¶
(11) Endodontic Services (CDT codes D3000-D3999):¶
(a) All radiographic images taken during the course of root canal therapy and all post-treatment radiographic images are included in the fee for the root canal procedure. At least one (1) pre-treatment radiographic image demonstrating the need for the procedure, and one (1) post-treatment radiographic image that demonstrates the result of the treatment, must be maintained in the member's record; ¶
(b) The Authority covers endodontic therapy as follows only when the crown-to-root ration is 50:50 or better and if the tooth is restorable to function with direct or indirect restoration without other surgical procedures:¶
(A) For EPSDT beneficiaries: all primary teeth, permanent anterior teeth, premolars, first molars and second molars (additional teeth are eligible with approved PA);¶
(B) For members who are pregnant or 12 months postpartum: permanent anterior teeth, premolars, and first molars; and¶
(C) For non-pregnant adults: anterior teeth and premolars.¶
(c) Endodontic retreatment and apicoectomy:¶
(A) The Authority does not cover retreatment of a previous root canal or apicoectomy for premolars or molars;¶
(B) The Authority 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 shall result in the need for removable prosthodontics.¶
(C) Retrograde filling is covered only when done in conjunction with a covered apicoectomy of an anterior tooth.¶
(d) The Authority 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) Apexification/recalcification procedures:¶
(A) The Authority limits payment for apexification to permanent teeth only;¶
(B) D3351-D3353 are limited to once (1) per tooth; and¶
(C) Covered only for EPSDT beneficiaries, or members who are pregnant or 12 months postpartum.¶
(12) Periodontic Services (CDT codes D4000-D4999):¶
(a) The Authority does not reimburse the following codes if performed on the same date of service D1110, D1120, D4210, D4211, D4341, D4346, D4355, and D4910.¶
(b) Surgical periodontal services:¶
(A) Gingivectomy/Gingivoplasty (D4210, D4211) coverage is limited to severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to dental hygiene procedures (e.g., medication-induced gingival hyperplasia), and includes six (6) months routine postoperative care (see Guideline Note 53 for criteria); and¶
(B) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212) is considered part of the restoration and is not separately billable.¶
(c) Non-surgical periodontal services:¶
(A) Removal of splints;¶
(B) Periodontal scaling and root planing (D4341, D4342) is allowed once (1) every two (2) years;¶
(i) Two (2) quadrants on one date of service is payable, except in extraordinary circumstances supported by documentation;¶
(ii) Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets of 5 mm or greater:¶
(C) Single implants may count as an additional tooth when billing, the number per quadrant and pocket depth requirements still apply;¶
(D) Full mouth debridement (D4355) allowed once (1) every two (2) years; and¶
(E) Scaling in the presence of generalized moderate or severe gingival inflammation, full mouth, after dental evaluation (D4346) is allowed once (1) every two (2) years.¶
(d) Periodontal maintenance (D4910) is allowed once (1) every six (6) months:¶
(A) Following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three (3) years; and¶
(B) Additional periodontal maintenance requires PA and may be requested when:¶
(i) Medically necessary and dentally appropriate, including situations involving periodontal disease during pregnancy; and¶
(ii) The member's medical record is submitted and supports the need for increased periodontal maintenance (chart notes, pocket depths and radiographs).¶
(e) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and radiographs;¶
(13) Prosthodontics, Removable (CDT codes D5000-D5899):¶
(a) The Authority covers complete dentures once (1) every 10 years, when medically necessary and dentally appropriate, with PA approval;¶
(A) Coverage is for only one of the following options (not both):¶
(i) Complete dentures (D5110, D5120); or¶
(ii) Immediate dentures (D5130, D5140);¶
(B) The Authority's 10-year coverage limitation applies regardless of the member's OHP or CCO enrollment at the time the denture was originally delivered;¶
(b) The fee for the denture includes payment for adjustments during the six (6) month period following the delivery of the denture. Adjustments and repairs needed beyond six (6) months from the delivery of the denture are covered by the Authority as follows:¶
(A) Four (4) times per year for:¶
(i) Adjustments (D5410, D5411);¶
(ii) Replacement of missing or broken teeth (D5520); and¶
(B) Two (2) times per year for broken denture base (D5511, D5512).¶
(C) Replacement of all teeth on complete denture (D5521, D5522), with PA approval:¶
(i) Once (1) per 10 years per arch; and¶
(ii) When five (5) or more years have passed since original delivery. ¶
(c) The Authority covers partial dentures once (1) every five (5) years when medically necessary and dentally appropriate, with PA approval;¶
(A) Coverage is for only one of the following options:¶
(i) Partial denture resin base (D5211, D5212);¶

(ii) Immediate partial denture (D5221, D5222)¶
(iii) Interim partial dentures (D5820, D5821);¶
(iv) Partial denture cast metal framework with resin base (D5213, D5214) and Immediate partial denture cast metal framework with resin base (D5223, D5224) are allowed only when there is medically documented that resin option is contraindicated. Reason could include: confirmed medical hypersensitivity to resin denture material; or the presence of palatal and/or lingual tori make fabrication of a resin partial denture impossible.¶
(B) The Authority's five (5) year coverage limitation applies regardless of the member's OHP or CCO enrollment status at the time the denture was originally delivered;¶
(C) Periodontal health must be stable and able to support a prosthetic;¶
(D) Interim partial dentures ("flippers") are covered only when at least one (1) anterior tooth is missing;¶
(E) Partial dentures are covered as follows:¶
(i) For EPSDT members: The member must have one (1) or more anterior teeth missing or four (4) or more posterior teeth missing per arch with documentation of serious masticating impairment. Third molars are not a consideration when counting missing teeth; and¶
(ii) For non-EPSDT members: The member must have one (1) or more missing anterior teeth or six (6) or more posterior teeth missing per arch with documentation of serious mastication impairment. Third molars are not a consideration when counting missing teeth;¶
(F) PA requests must note both the teeth to be replaced and the teeth to be clasped with requesting PA;¶
(G) The Authority does not approve resin partial dentures (D5211, D5212) if stainless steel crowns are used as abutments; and¶
(H) Partial dentures may not be used in lieu of space maintainers. ¶
(d) Fees for the partial denture includes adjustments and repairs for six (6) months following delivery. Coverage after six (6) months is as follows:¶
(A) Four (4) times per year for adjustments per arch (D5421, D5422), replacement of broken tooth (D5640), and adding tooth to existing partial denture (D5650);¶
(B) Two (2) times per year for repairs to base (D5611, D5612), framework (D5621, D5622), retentive/clasping materials (D5630); and adding clasp to existing partial denture(D5660);¶
(C) Replacement of all partial denture teeth and acrylic on cast metal framework (D5670, D5671), with PA approval:¶
(i) Once (1) per five (5) years per arch only after five (5) or more years since original delivery; and¶
(ii) Is considered a partial denture replacement; another partial will not be reimbursed for five (5) years.¶
(e) Reimbursement requirements:¶
(A) Member must have active coverage on the date of the final impression;¶
(B) Dentures must be delivered within 45 days of the final impression; and¶
(C) Claims must include both the date of the final impression and the date of delivery. If the member loses OHP coverage before delivery, the claim should be submitted using the date of the final impression.¶
(f) The Authority may cover reasonable and necessary replacement of medically necessary and dentally appropriate covered dentures, including those purchased or in used before the member enrolled with OHP when;¶
(A) The item cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement);¶
(B) The loss of the item is due to circumstance beyond the member's control (e.g., irreparable damage referring to a specific accident, natural disaster, or situation);¶
(C) The member's condition changes that warrants a new item (e.g., cases of acute trauma, catastrophic illness that directly or indirectly affects the dental condition and results in additional tooth loss). This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical, and medical treatment for conditions mentioned earlier; and¶
(D) Coverage exists for the item.¶
(g) Replacement may not be covered when:¶
(A) Malicious damage, culpable neglect, or wrongful disposition of the denture is suspected; or¶
(B) Severe periodontal disease is present.¶
(h) Replacement of a partial denture with a complete denture is payable five (5) years after the partial denture placement;¶
(i) The Authority covers denture rebase procedures (D5710, D5711, D5720, D5721) only when reline does not adequately solve the problem:¶
(A) For EPSDT members: once (1) every three (3) years;¶
(B) For non-EPSDT members: once (1) every five (5) years when there is documentation of a current, failed reline procedure;¶
(C) Exceptions to these limitations may be considered by the Authority for conditions as listed for warranting replacement of partial and complete dentures; and¶

(D) Untreated severe periodontal disease may not warrant rebase procedures.¶
(j) The Authority covers denture reline (direct) procedures (D5730, D5731, D5740, D5741) as follows:¶
(A) For EPSDT members -once (1) every three (3) years;¶
(B) For non-EPSDT members - once (1) every five (5) years;¶
(C) A new or replacement complete or partial denture(s) on the same arch are not reimbursable for 12 months after the reline; and¶
(D) Exceptions to these limitations may be considered by the Authority for conditions as listed for warranting replacement of partial and complete dentures.¶
(k) The Authority covers denture reline (indirect) laboratory procedures (D5750, D5751, D5760, D5761) six (6) months after placement of any denture as follows:¶
(A) For EPSDT members once (1) every three (3) years;¶
(B) For non-EPSDT members once (1) every five (5) years;¶
(C) A new or replacement denture on the same arch is not reimbursable for 12 months after the reline; and¶
(D) Exceptions to these limitations may be considered by the Authority for conditions as listed for warranting replacement of partial and complete dentures.¶
(l) The Authority covers tissue conditioning (D5850, D5851) once per denture unit in conjunction with immediate dentures and once before new denture placement.¶
(14) Maxillofacial Prosthetic Services (CDT codes D5900-D5999):¶
(a) Any maxillofacial prosthesis service that has a specified medical CPT code should be billed to the medical benefit using the professional claims forms.¶
(b) Fluoride gel carrier is covered for members whose severity of dental disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The provider must document prior failure of those options as clinical justification;¶
(c) Repair of maxillofacial prosthesis, by report (D5998) is covered;¶
(d) The Authority covers the following prosthesis appliances when provided in association with cancer of bones, in accordance with Guideline Notes 12, 16, and 231;¶
(A) Guidance prosthesis (D5909, D5930, D5934, D5935); and¶
(B) Resection prosthesis (D5938-D5949);¶
(C) Repair of maxillofacial prosthesis is covered, by report.¶
(e) The Authority covers the following only for EPSDT or by exception for treatment of craniofacial anomalies and handicapping malocclusion (D5915, D5919, D5925, D5926, D5929, D5931).¶
(f) All other maxillofacial prosthetics are to be billed as medical services using the professional claim format (CMS1500, DMAP 505, 837D or 837P);¶
(A) If the member is assigned to a CCO, bill the CCO; and¶
(B) If the member is assigned to FFS, bill the Authority.¶
(15) Prosthodontics, Fixed (CDT codes D6200-D6999):¶
(a) The Authority covers the following in the presence of advance peri-implantitis with bone loss and mobility, or abscess, or with implant fracture (per Guideline Note 123):¶
(A) Surgical removal of implant body (D6100) and¶
(B) Removal of implant body (D6105);¶
(b) Coverage is for all members.¶
(16) Oral & Maxillofacial Surgery (D7000-D7999): Billing Procedures:¶
(a) Bill on a dental claim form using CDT codes for procedures that are directly related to the teeth and the structures directly supporting teeth;¶
(b) The Medical/Surgical Program chapter 410, division 130 is responsible for all oral health procedures performed due to an underlying medical condition (i.e., procedures on or in preparation for treatment of the jaw, tongue, roof of mouth). Such procedures must be billed using ICD-10, HCPCS and CPT billing codes using the professional claim format (CMS1500, DMAP 505 or 837P);¶
(c) The following services are covered based on severity and included situations deemed to cause gingival recession or movement of the gingival margin when frenum is placed under tension:¶
(A) Buccal/labial frenectomy (frenulectomy) (D7961), refer to Guideline Note 48;¶
(i) Maxillary labial frenulectomy is not covered until age 12; and¶
(ii) Not billable if member has received D7963; ¶
(B) Lingual frenectomy (frenulectomy) (D7962), refer to Guideline Note 48 and 139, is not covered until age 12 unless ankyloglossia is interfering with breastfeeding; or¶
(C) Frenuloplasty (D7963), refer to Guideline Note 48;¶
(i) Once (1) per lifetime per quadrant; and¶
(ii) Not billable if member has received D7961.¶
(d) Emergency tracheotomy (D7990) is an ancillary code reimbursable for all members;¶

(e) All covered ancillary and diagnosis codes must be used for services that are medically necessary and dentally appropriate;¶
(f) The Authority covers Alveoloplasty as follows:¶
(A) Alveoloplasty not in conjunction with extractions (D7320, D7321) is reimbursable for EPSDT beneficiaries, and for members who are pregnant or 12 months postpartum ;¶
(B) Alveoloplasty in conjunction with extractions (D7310, D7311) is not eligible for separate reimbursement;¶
(g) Post extraction treatment for alveolitis (dry socket treatment) cannot be billed by the provider that billed for the extraction;¶
(h) Salivary gland procedures are to be billed using Medical CPT codes; and¶
(17) Orthodontics (CDT Codes D8000-D8999):¶
(a) Orthodontic coverage is only for EPSDT beneficiaries. The Authority covers orthodontia services and extractions to treat cleft palate with airway obstruction, cleft palate and/or cleft lip, or deformities of the head, and handicapping malocclusions (HM), not for cosmetic purposes, as follows:¶
(A) The member has a craniofacial anomaly health condition that is included on the OHA Prioritized List of Health Services;¶
(B) The Authority approves the PA request for orthodontic treatment; and¶
(C) EPSDT qualification for the OHP Orthodontic benefit is determined when;¶
(i) Dental Appropriateness as demonstrated when the member has a malocclusion; and¶
(ii) Medical Necessity for the orthodontic treatment is demonstrated when the member meets the automatic qualifying criteria and/or a score of 26 or higher on the Handicapping Labiolingual Deviation (HLD) score index.¶
(b) Pre-orthodontic treatment examinations (D8660) must be provided by a licensed dentist.¶
(c) Pre-orthodontic treatment examinations (D8660) do not require PA. Coverage is for members whose clinical presentation and preliminary comprehensive or periodic exam findings strongly suggest that they may qualify for orthodontic treatment under HM criteria, as established by the Authority. The imaging required for evaluation is not to be billed separately. Coverage is:¶
(A) Once (1) per member, per provider, in a 12-month period (not on the same day as another routine or general dental evaluation or examination); and¶
(B) When submitted alongside the following documentation to justify the need for treatment:¶
(i) The Authority-approved HLD Index California Modified Scoring Form (completed, scored, and signed);¶
(ii) Intra-oral and extra-oral photographs of diagnostic quality, adhering to American Association of Orthodontists (AAO) standards, capturing key aspects of the malocclusion;¶
(iii) Panoramic radiographs or cephalometric images including tracings that document skeletal and dental relationships crucial for evaluating the severity of malocclusion; and¶
(iv) A comprehensive narrative of medical necessity, explicitly stating how the malocclusion significantly impacts the member's oral health, airway, or overall functional capacity.¶
(d) PA approval for limited (D8010, D8020, D8030, D8040) and comprehensive (D8070, D8080, D8090, D8091) orthodontic treatment must meet the criteria in HERC Guideline Note 169 of the OHA Prioritized List of Health Service.¶
(e) Comprehensive orthodontic treatment must be completed by a licensed dentist who has:¶
(A) Completed a Commission of Dental Accreditation (CODA) orthodontic fellowship or residency program;¶
(B) Certified additional orthodontic training, a minimum of 30 hours of orthodontic continuing education (CE) in the past three (3) years that was approved by the American Dental Association Continuing Education Recognition Program (ADA CERP); or¶
(C) Completed five (5) comprehensive orthodontic treatment cases in the past three (3) years, verified by case logs and patient outcomes.¶
(f) Orthodontic treatment must begin while the member is an EPSDT beneficiary, or immediately after, if surgical corrections that were started during the member's EPSDT beneficiary period for covered conditions were not completed during that period.¶
(g) Payment for comprehensive orthodontic treatment includes all appliances, repairs, and all follow-up visits.¶
(h) The Authority pays for orthodontia in one (1) lump sum upon beginning of treatment;¶
(A) If the member transfers to another orthodontic provider during the course of treatment, or if treatment is terminated, the provider must inform the Authority and the Authority shall recover the overpayment (refer to OAR 410-120-1397) based on the length of the treatment plan from the first date of service (DOS); and¶
(B) Providers may discontinue orthodontic treatment of a member in cases including poor dental hygiene, continued missed appointments, or if treatment is a detriment to the member.¶
(i) Licensed dentists providing orthodontic treatment may:¶
(A) Submit PA requests for the extractions and/or bond surgeries that are documented as needed in the member's orthodontic treatment plan; and¶
(B) Refer members to enrolled specialists for extractions and/or bond surgeries when such services are beyond the

scope of the member's primary care dentist.¶
(j) As long as the orthodontist continues treatment, the Authority may not require a refund even though the member may become ineligible for medical assistance sometime during the treatment period.¶
(k) Care navigation assistance for members must be made available during transfer of care in situations such as provider changes.¶
(18) Adjunctive General and Other Services (CDT codes D9000-D9999):¶
(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 and sedation:¶
(A) The Authority reimburses administration of general anesthesia or IV sedation only for those members with concurrent needs: age; physical, medical, or mental status; or degree of difficulty of the procedure; and¶
(B) The Authority reimburses providers with a current permit to administer General Anesthesia or IV Sedation as follows:¶
(i) For each 15-minute period, up to two and a half hours on the same day of service in a dental office setting, and up to three and a half hours on the same day of service in a hospital setting and ASC;¶
(ii) Each 15-minute period represents a quantity of one (1). Enter this number in the quantity column.¶
(C) The Authority reimburses administration of Nitrous Oxide per date of service, not by time;¶
(D) Enteral and non-intravenous parenteral conscious sedation with or without coadministration of Nitrous Oxide are covered only for EPSDT beneficiaries as follows:¶
(i) Members age 13 and older require PA;¶
(ii) Limited to four (4) times per year; and¶
(iii) Includes payment for monitoring and Nitrous Oxide;¶
(E) Upon request, providers must submit a copy of their permit to administer Anesthesia, Analgesia, and Sedation to the Authority; and¶
(F) The Authority covers CPT 00170 (anesthesia services during procedures on the mouth). When billing for services provided in conjunction with dental treatments in the office setting, use the professional claim format using an appropriate non-facility Place of Service code¶
(c) House/extended care facility call (D9410) is limited to 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's or facility's convenience.¶
(19) Sleep Apnea Services:¶
(a) Sleep apnea devices and appliances may be placed or fabricated by a general dentist or specialist although they are considered medical services;¶
(b) Bill for sleep apnea services using medical billing codes on the professional claim form unless guidance specifies otherwise;¶
(c) Custom sleep apnea appliance fabrication and placement (D9947) must be billed on a dental claim form (see Guideline Notes 27 and 36 for criteria), and is replaceable at the end of the five (5) year reasonable useful lifetime;¶
(d) The Authority does not cover adjustments for dental sleep apnea appliances. The adjustments are considered part of the normal follow-up care within the first 90 days after provision of the device, and are included as services of (D9947); and¶
(e) Dental sleep apnea repairs (D9949) are covered when necessary and appropriate to make item serviceable. If the expense for repairs exceeds the estimated expense of purchasing another item, no payment must be made for the excess.¶
(20) Dental care access standards for pregnant members:¶
(a) Dental care benefits for pregnant members shall continue for 12 months following the end of pregnancy; and¶
(b) For additional dental care benefit for members who are pregnant or 12 months postpartum, refer to OAR 410-123-1510.¶
(21) Under the Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS) issued regulations in 2024 for payment for dental services that are inextricably linked to certain covered medical services, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, valvuloplasty procedures, and treatments for head and neck cancers. Such services should be billed directly to Medicare.¶
(22) Services considered incidental, integral to the primary service rendered, part of another service, or included in routine post-op or follow-up care are not eligible for separate reimbursement: Submitting claims for the following services is for documentation and reporting purposes only:¶
(a) Alveolectomy/Alveoloplasty in conjunction with extractions (D7310, D7311);¶
(b) Cardiac and other monitoring;¶

(c) Caries risk assessment and documentation (D0601-D0603);¶
(d) Periodontal scaling and root planing - per tooth is not eligible for separate reimbursement unless the service is significant and separately identifiable;¶
(e) Diagnostic casts (D0470);¶
(f) Direct pulp cap (D3110);¶
(g) Discing (recontouring of adjacent teeth);¶
(h) Dressing change;¶
(i) Gingival irrigation (D4921);¶
(j) Gingivectomy or gingivoplasty to allow for access for restorative procedure, per tooth (D4212);¶
(k) Indirect pulp cap (D3120);¶
(l) Local anesthesia (D9210, D9215);¶
(m) Medicated pulp chambers;¶
(n) Occlusal adjustments (D9951, D9952);¶
(o) Occlusal analysis (D9950);¶
(p) Odontoplasty (D9971);¶
(q) Oral hygiene instruction (D1330);¶
(r) Periodontal charting, probing;¶
(s) Post removal (D2955);¶
(t) Polishing fillings;¶
(u) Post extraction treatment for alveolaritis (D9930) if done by the provider of the extraction;(v) Pulp vitality tests (D0460);¶
(w) Smooth broken tooth;¶
(x) Special infection control procedures;¶
(y) Surgical procedure for isolation of tooth with rubber dam (D3910);¶
(z) Surgical splint (D5988);¶
(aa) Surgical stent (D5982);¶
(bb) Suture removal; and¶
(cc) Testing for cracked tooth (D0461).¶
(dd) Teledentistry (D9995, D9996;¶
(ee) Drugs/medicaments dispensed in the office for home use (D9630); and¶
(ff) Evaluation for moderate sedation, deep sedation or general anesthesia (D9219).¶
(23) Unless coverage is specified or the member is an EPSDT beneficiary meeting requirements of OAR chapter 410, division 151, the following are not covered:¶
(a) Desensitization;¶
(b) Implant and implant services (See OHA Prioritized List Guideline Notes 123 and 169);¶
(c) Mastique or veneer procedure;¶
(d) Orthodontic treatment;¶
(e) Overhang removal;¶
(f) Procedures, appliances, or restorations solely for aesthetic or cosmetic purposes;¶
(g) Temporomandibular joint (TMJ) dysfunction treatment; and¶
(h) Tooth bleaching.¶
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Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-123-1265

RULE SUMMARY: Revise rules related to reimbursement for teledentistry.

CHANGES TO RULE:

410-123-1265
Teledentistry
(1) Teledentistry can ~~take multiple forms, both~~be delivered through multiple modes, some of which occur simultaneously, in real-time, also known as synchronous, and ~~asynchronous,~~others which do not occur in real-time, also known as asynchronous. These modes includ~~ing~~e, but are not limited to the following:¶
(a) Live video~~,~~ - a two-way interaction between a member 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~~ who may be located at a distant site who reviews the ~~information~~transmission at a later point in time without the member being present in real time;¶
(c) Remote member 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 that may support mobile dentistry, health care, public health practices, and education.¶
(2) A member receiving services through teledentistry must be notified of the right to receive interactive communication with the distant dentist and must receive an interactive communication with the distant dentist upon request;¶
(a) The member's chart documentation must reflect notification of the right to interactive communication with the distant site dentist; and¶
(b) A member may request to have real time communication with the d~~istant dentist at the time of the visit or~~entist who reviews the member's asynchronous visit transmission, within 30 days of the ~~original~~ visit.¶
(3) Providers must be licensed to practice dentistry and enrolled as a Medicaid provider as required by OAR 410-120-1260.~~.~~¶
(4) All ~~Dental Services~~chapter 410, division 123 rules, criteria, limits, and billing requirements apply to teledentistry services in the same manner as ~~other services.¶~~
~~(5) Providers billing for covered~~services provided in person.¶
(5) Providers using teledentistry services must follow all telehealth requirements in OAR 410-120-1990, which include, without limitation:¶
(a) Complying with Health Insurance Portability and Accountability Act (HIPAA) and Oregon Health Authority (OHA) Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records;¶
(b) Obtaining and maintaining technology used in the telehealth communication that is compliant with privacy and security standards;¶
(c) Ensuring policies and procedures are in place to prevent a breach in privacy or exposure of member health information or records (whether oral or recorded in any form or medium) to unauthorized individuals; and¶
(d) Maintaining clinical and financial documentation related to telehealth services as required in OAR 410-120-1360 and OAR 410-120-1990.¶
(6) General Billing Requirements:¶
(a) Unless authorized in the Telehealth rule of Medical Assistance Programs, OAR 410-120-1990, other types of telecommunications such as telephone calls, images transmitted via facsimile machines, and electronic mail ~~are~~ do not ~~covered;¶~~
~~(b) The dentist may bill for teledentistry~~qualify as teledentistry;¶
(b) For documentation and reporting, the dentist may submit claims on the same type of claim form as other types of procedures unless ~~in~~doing so would conflict with the Dental/Denturist Services rules~~; and¶~~
~~(c) 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-~~ set out in chapter 410, division 123; and¶
(c) Reimbursements paid by the Authority on claims for the provision of dental services are the same regardless of whether the services are provided via teledentistry or in person.¶
(7) Teledentistry billing requirements:¶
(a) The dentist who completes diagnosis and treatment planning and the oral evaluation ~~also~~ documents these services using the ~~traditional~~same Current Dental Terminology (CDT) codes~~;~~ that are used for providing the same

services in person;¶
(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;¶
(c) The provider must report the teledentistry event using the teledentistry billing codes for synchronous (D9995) or asynchronous (D9996), as appropriate~~; and¶~~
~~(d) D9995 and D9996 are not eligible for separate reimbursement~~ including using appropriate place of service on the claim form; and¶
(d) The Authority does not provide separate reimbursement for D9995 and D9996.¶
(A) These billing codes identify the modality through which the dental service was delivered and are not eligible for separate reimbursement; and¶
(B) Reimbursement is based on the underlying covered dental services provided in accordance with OAR 410-123-1260.
Statutory/Other Authority: ORS 679.543, ORS 414.065
Statutes/Other Implemented: ORS 414.065