12-15

Secretary of State
Certificate and Order for Filing
PERMANENT ADMINISTRATIVE RULES

I certify that the attached copies* are true, full and correct copies of the PERMANENT Rule(s) adopted on 11/24/10 by the
Date prior to or same as filing date

Department of Human Services, Division of Medical Assistance Programs 410
Agency and Division — Administrative Rules Chapter Number

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to become effective 1/1/2011. Rulemaking Notice was published in the 11/1/2010. *Oregon Bulletin.***
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DMAP 31-2010

RULEMAKING ACTION

Rule Filing Caption: 2011 – client copayments; tobacco cessation; CAWEM Program

AMEND: 410-123-1000, 410-123-1220, 410-123-1260, and 410-123-1540
REPEAL: 410-123-1085

Statutory Authority: ORS 409.050, 414.065 and 414.707
Other Authority: None
Statutes Implemented: ORS 414.065 and 414.707

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Summary:

The Dental Services Program administrative rules govern Division payment for services to certain clients. The Division amended rules to reference client co-payments addressed in General Rules Program OAR 410-120-1230; to reference the updated "Covered and Non-Covered Services document"; to change language regarding billing for tobacco cessation, which coincides with 2011 Dental Care Organization contract language; to clarify language regarding the Citizen/Alien-Waived Emergency Medical (CAWEM) program and add clarification regarding the dental coverage for clients under the Children's Health Insurance Program (CHIP) Pilot Project prenatal coverage; and other minor clarifications.

The Division repealed 410-123-1085 (Client co-payments) as these policies are covered in General Rules Program rule (OAR 410-120-1230).

The Division amended rules to clarify current policies and procedures to ensure these rules are not open to interpretation by the provider or outside parties and to help eliminate confusion possibly resulting in non-compliance and help facilitate provider compliance with eligibility, service coverage and limitations, and billing requirements.

Other text may be revised to improve readability and to take care of necessary "housekeeping" corrections.

12-6-10

Authorized Signer: Judy Mohr Peterson, Lynn Read or Jean Phillips — Date

410-123-1000
Eligibility, Providing Services and Billing
(1) Eligibility:
(a) Providers are responsible to verify client eligibility and must do so before providing any service or billing the Division of Medical Assistance Programs (Division) or any Oregon Health Plan (OHP) Prepaid Health Plan (PHP);
(b) The Division may not pay for services provided to an ineligible client even if services were authorized. Refer to General Rules OAR 410-120-1140 (Verification of Eligibility) for details.
(2) Co-payments for OHP clients may be required for certain services. See General Rules OAR 410-120-1230 for specific information on co-pays.
(3) Billing:
(a) Providers must follow the Division rules in effect on the date of service. All Division rules are intended to be used in conjunction with the Division's General Rules Program (chapter 410, division 120), the OHP Administrative Rules (chapter 410, division 141), Pharmaceutical Services Rules (chapter 410, division 121) and other relevant Division OARs applicable to the service provided, where the service is delivered, and the qualifications of the person providing the service including the requirement for a signed provider enrollment agreement;
(b) Third Party Resources: A third party resource (TPR) is an alternate insurance resource, other than the Division, available to pay for medical/dental services and items on behalf of OHP clients. Any alternate insurance resource must be billed before the Division or any OHP PHP can be billed. Indian Health Services or Tribal facilities are not considered to be a TPR pursuant to the Division's General Rules Program rule (OAR 410-120-1280);
(c) Fabricated Prosthetics:
(A) If a dentist or denturist provides an eligible client with fabricated prosthetics that require the use of a dental laboratory, the date of the final impressions must have occurred:
(i) Prior to the client's loss of eligibility; and
(ii) For dentures for non-pregnant adults, no later than six months from the date of the last extraction from the jaw for which the denture is being provided;
(B) The dentist/denturist should use the date of final impression as the date of service only when criteria in (A) is met and the fabrication extends beyond:
(i) The client's OHP eligibility; or
(ii) Six months after the extractions (for dentures for non-pregnant adults);
(C) The date of delivery must be within 45 days of the date of the final impression and the date of delivery must also be indicated on the claim. These are the only exceptions to the Division's General Rules Program rule (OAR 410-120-1280). All other services must be billed using the date the service was provided;
(d) Refer to OAR 410-123-1160 for information regarding dental services requiring prior authorization (PA). Refer to OAR 410-123-1100 for information regarding dental services that require providers to submit reports for review ("by report" - BR) prior to reimbursement;
(e) The client's records must include documentation to support the appropriateness of the service and level of care rendered;
(f) The Division shall only reimburse for dental services that are dentally appropriate as defined in OAR 410-123-1060;
(g) Refer to OAR chapter 410, division 147 for information about reimbursement for dental services provided through a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC);

(4) Treatment Plans: Being consistent with established dental office protocol and the standard of care within the community, scheduling of appointments is at the discretion of the dentist. The agreed upon treatment plan established by the dentist and patient shall establish appointment sequencing. Eligibility for medical assistance programs does not entitle a client to any services or consideration not provided to all clients.
Stat. Auth.: ORS 409.050 and 414.065
Stats. Implemented: ORS 414.065

410-123-1220
Coverage according to the Prioritized List of Health Services
This rule incorporates by reference the "Covered and Non-Covered Dental Services" document, dated January 1, 2011, and located on the Department of Human Services Web site at: www.dhs.state.or.us/policy/healthplan/guides/dental/main.html.
(a) The "Covered and Non-Covered Dental Services" document lists coverage of Current Dental Terminology (CDT) procedure codes according to the Oregon Health Services Commission (HSC) Prioritized List of Health Services (HSC Prioritized List) and the client's specific Oregon Health Plan benefit package;
(b) This document is subject to change if there are funding changes to the HSC Prioritized List.
(2) Changes to services funded on the HSC Prioritized List are effective on the date of the HSC Prioritized List change:
(a) The Division of Medical Assistance Programs (Division) administrative rules (chapter 410, division 123) will not reflect the most current HSC Prioritized List changes until they have gone through the Division rule filing process;
(b) For the most current HSC Prioritized List, refer to the HSC Web site at www.oregon.gov/OHPPR/HSC/current_prior.shtml;
(c) In the event of an alleged variation between a Division-listed code and a national code, the Division shall apply the national code in effect on the date of request or date of service.
(3) Refer to OAR 410-123-1260 for information about limitations on procedures funded according to the HSC Prioritized List. Examples of limitations include frequency and client's age.
(4) The HSC Prioritized List does not include or fund the following general categories of dental services and the Division does not cover them for any client. Several of these services are considered elective or "cosmetic" in nature (i.e., done for the sake of appearance):
(a) Desensitization;
(b) Implant and implant services;
(c) Mastique or veneer procedure;
(d) Orthodontia (except when it is treatment for cleft palate);
(e) Overhang removal;
(f) Procedures, appliances or restorations solely for aesthetic/ cosmetic purposes;
(g) Temporomandibular joint dysfunction treatment; and
(h) Tooth bleaching.
Stat. Auth.: ORS 409.050 and 414.065
Stats. Implemented: ORS 414.065

410-123-1260 OHP
Plus Dental Benefits
(1) GENERAL:
(a) Early and Periodic Screening, Diagnosis and Treatment (EPSDT):
(A) Refer to Code of Federal Regulations (42 CFR 441, Subpart B) and OAR chapter 410, division 120 for definitions of the EPSDT program, eligible clients, and related services. EPSDT dental services includes, but are not limited to:
(i) Dental screening services for eligible EPSDT individuals; and
(ii) Dental diagnosis and treatment which is indicated by screening, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health;
(B) Providers must provide EPSDT services for eligible Division of Medical Assistance Programs (Division) clients according to the following documents:
(i) The Dental Services Program administrative rules (OAR chapter 410, division 123), for dentally appropriate services funded on the Oregon Health Services Commission Prioritized List of Health Services (HSC Prioritized List); and
(ii) The "Oregon Health Plan (OHP) – Recommended Dental Periodicity Schedule," dated January 1, 2010, incorporated by reference and posted on the Department of Human Services Web site in the Dental Services Supplemental Information document at www.dhs.state.or.us/policy/healthplan/guides/dental/main.html;
(b) Restorative, periodontal and prosthetic treatments:
(A) Such treatments must be consistent with the prevailing standard of care, documentation must be included in the client's charts to support the treatment, and may be limited as follows:
(i) When prognosis is unfavorable;
(ii) When treatment is impractical;
(iii) A lesser-cost procedure would achieve the same ultimate result; or
(iv) The treatment has specific limitations outlined in this rule;
(B) Prosthetic treatment (including porcelain fused to metal crowns) are limited until rampant progression of caries is arrested and a period of adequate oral hygiene and periodontal stability is demonstrated; periodontal health needs to be stable and supportive of a prosthetic.
(2) DIAGNOSTIC SERVICES:
(a) Exams:
(A) For children (under 19 years of age):
(i) The Division shall reimburse exams (billed as D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations:
(I) D0150: once every 12 months when performed by the same practitioner;
(II) D0150: twice every 12 months only when performed by different practitioners;
(III) D0180: once every 12 months;
(ii) The Division shall reimburse D0160 only once every 12 months when performed by the same practitioner;
(B) For adults (19 years of age and older) – The Division shall reimburse exams (billed as D0120, D0150, D0160, or D0180) by the same practitioner once every 12 months;
(C) For each emergent episode, use D0140 for the initial exam. Use D0170 for related dental follow-up exams;

(D) The Division only covers oral exams by medical practitioners when the medical practitioner is an oral surgeon;
(E) As the American Dental Association's Current Dental Terminology (CDT) codebook specifies the evaluation, diagnosis and treatment planning components of the exam are the responsibility of the dentist, the Division does not reimburse dental exams when furnished by a dental hygienist (with or without a limited access permit);
(b) Radiographs:
(A) The Division shall reimburse for routine radiographs once every 12 months;
(B) The Division shall reimburse bitewing radiographs for routine screening once every 12 months;
(C) The Division shall reimburse a maximum of six radiographs for any one emergency;
(D) For clients under age six, radiographs may be billed separately every 12 months as follows:
(i) D0220 -- once;
(ii) D0230 -- a maximum of five times;
(iii) D0270 -- a maximum of twice, or D0272 once;
(E) The Division shall reimburse for panoramic (D0330) or intra-oral complete series (D0210) once every five years, but both cannot be done within the five-year period;
(F) Clients must be a minimum of six years old for billing intra-oral complete series (D0210). The minimum standards for reimbursement of intra-oral complete series are:
(i) For clients age six through 11- a minimum of 10 periapicals and two bitewings for a total of 12 films;
(ii) For clients ages 12 and older - a minimum of 10 periapicals and four bitewings for a total of 14 films;
(G) If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), the Division shall reimburse for the complete series;
(H) Additional films may be covered if dentally or medically appropriate, e.g., fractures (Refer to OAR 410-123-1060 and 410-120-0000);
(I) If the Division determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area may be denied;
(J) The exception to these limitations is if the client is new to the office or clinic and the office or clinic was unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records must be included in the client's records;
(K) Digital radiographs, if printed, should be on photo paper to assure sufficient quality of images.
(3) PREVENTIVE SERVICES:
(a) Prophylaxis:
(A) For children (under 19 years of age) – Limited to twice per 12 months;
(B) For adults (19 years of age and older) -- Limited to once per 12 months;
(C) Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, pregnancy, medications or other medical treatments or conditions, severe periodontal disease, rampant caries and/or for persons with disabilities who cannot perform adequate daily oral health care;
(D) Are coded using the appropriate Current Dental Terminology (CDT) coding:
(i) D1110 (Prophylaxis – Adult) – Use for clients 14 years of age and older; and
(ii) D1120 (Prophylaxis – Child) – Use for clients under 14 years of age;

(b) Topical fluoride treatment:
(A) For adults (19 years of age and older) -- Limited to once every 12 months;
(B) For children (under 19 years of age) – Limited to twice every 12 months;
(C) For children under 7 years of age who have limited access to a dental practitioner, topical fluoride varnish may be applied by a medical practitioner during a medical visit:
(i) Bill the Division directly regardless of whether the client is fee-for-service (FFS) or enrolled in a Fully Capitated Health Plan (FCHP) or Physician Care Organization (PCO);
(ii) Bill using a professional claim format with the appropriate CDT code (D1206 – Topical Fluoride Varnish);
(iii) An oral screening by a medical practitioner is not a separate billable service and is included in the office visit;
(D) Additional topical fluoride treatments may be available, up to a total of 4 treatments per client within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for the following clients who:
(i) Have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;
(ii) Are pregnant;
(iii) Have physical disabilities and cannot perform adequate, daily oral health care;
(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care; or
(v) Are under seven year old with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc;
(c) Sealants:
(A) Are covered only for children under 16 years of age;
(B) The Division limits coverage to:
(i) Permanent molars; and
(ii) Only one sealant treatment per molar every five years, except for visible evidence of clinical failure;
(d) Tobacco cessation:
(A) For services provided during a dental visit, bill as a dental service using CDT code D1320 when the following brief counseling is provided:
(i) Ask patients about their tobacco-use status at each visit and record information in the chart;
(ii) Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco and a strong personalized message to seek help; and
(iii) Refer patients who are ready to quit, utilizing internal and external resources to complete the remaining three A's (assess, assist, arrange) of the standard intervention protocol for tobacco;
(B) The Division allows a maximum of 10 services within a three-month period;
(C) For tobacco cessation services provided during a medical visit follow criteria outlined in OAR 410-130-0190;
(e) Space management:
(A) The Division shall cover fixed and removable space maintainers (D1510, D1515, D1520, and D1525) only for clients under 19 years of age;
(B) The Division may not reimburse for replacement of lost or damaged removable space maintainers.
(4) RESTORATIVE SERVICES:
(a) Restorations -- amalgam and composite:

(A) Resin-based composite crowns on anterior teeth (D2390) are only covered for clients under 21 years of age or who are pregnant;
(B) The Division limits payment to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) CDT codebook for definitions of restorative procedures;
(C) Combine and bill one line per tooth using the appropriate code. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces);
(D) The Division may not reimburse for an amalgam or composite restoration and a crown on the same tooth;
(E) The Division reimburses for a surface once in each treatment episode regardless of the number or combination of restorations;
(F) The restoration fee includes payment for occlusal adjustment and polishing of the restoration;
(G) The Division reimburses for posterior composite restorations at the same rate as amalgam restorations;
(H) The Division limits payment for replacement of posterior composite restorations to once every five years;
(b) Crowns:
(A) Acrylic heat or light cured crowns (D2970) -- allowed only for anterior permanent teeth;
(B) The following types of crowns are covered only for clients under 21 years of age or who are pregnant:
(i) Prefabricated plastic crowns (D2932) -- allowed only for anterior teeth, permanent or primary;
(ii) Stainless steel crowns (D2930/D2931) — allowed only for posterior teeth, permanent or primary;
(iii) Prefabricated stainless steel crowns with resin window (D2933) – allowed only for anterior teeth, permanent or primary;
(C) Permanent crowns (resin-based composite - D2710, and porcelain fused to metal (PFM) - D2751 and D2752):
(i) Limited to teeth numbers 6-11, 22 and 27 only, if dentally appropriate;
(ii) Up to four (4) permanent crowns allowed in a seven-year period;
(iii) A replacement of a crown previously covered under OHP is included in the maximum limit of 4 permanent crowns, and would need to meet the criteria for a replacement crown;
(iv) Only allowed for clients at least 16 years and under 21 years of age or who are pregnant; and
(v) Rampant caries are arrested and the client demonstrates a period of oral hygiene before prosthetics are proposed;
(vi) PFM crowns (D2751 and D2752) must also meet the following additional criteria:
(I) The dental practitioner has attempted all other dentally appropriate restoration options, and documented failure of those options;
(II) Written documentation in the client's chart indicates that PFM is the only restoration option that will restore function;
(III) The dental practitioner submits radiographs to the Division for review; history, diagnosis, and treatment plan may be requested. See OAR 410-123-1100 (Services Reviewed by the Division of Medical Assistance Programs);
(IV) The client has documented stable periodontal status with pocket depths within 1 – 3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeter and over, documentation must be maintained in the client's chart of the dentist's findings supporting

stability and why the increased pocket depths will not adversely affect expected long term prognosis;
(V) The crown has a favorable long-term prognosis; and
(VI) If tooth to be crowned is clasp/abutment tooth in partial denture, both prognosis for crown itself and tooth's contribution to partial denture must have favorable expected long-term prognosis;
(D) The fee for the crown includes payment for preparation of the gingival tissue;
(E) The Division limits payment for retention pins to four per tooth;
(F) Prefabricated post and core in addition to crowns (D2954 and D2957) is only covered for clients under 21 years of age or who are pregnant;
(G) The Division covers crowns only when there is significant loss of clinical crown and no other restoration will restore function:
(i) The Division shall cover crowns if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;
(ii) The following is not covered:
(I) Endodontic therapy alone (with or without a post);
(II) Aesthetics (cosmetics);
(III) Crowns in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason;
(H) The Division limits permanent crown replacement to once every seven years and all other crown replacement to once every five years per tooth and only when dentally appropriate. The Division may make exceptions to this limitation for crown damage due to acute trauma, based on the following factors:
(i) Extent of crown damage;
(ii) Extent of damage to other teeth or crowns;
(iii) Extent of impaired mastication;
(iv) Tooth is restorable without other surgical procedures; and
(v) If loss of tooth would result in coverage of removable prosthetic.
(5) ENDODONTIC SERVICES:
(a) Pulp capping:
(A) The Division includes direct and indirect pulp caps in the restoration fee; no additional payment shall be made for clients with the OHP Plus benefit package;
(B) The Division covers direct pulp caps as a separate service for clients with the OHP Standard benefit package because restorations are not a covered benefit under this benefit package;
(b) Endodontic therapy:
(A) Endodontic therapy (D3230, D3240, D3330) is covered only for clients under 21 years of age or who are pregnant;
(B) The Division covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;
(c) Endodontic retreatment and apicoectomy/periradicular surgery:
(A) The Division does not cover retreatment of a previous root canal or apicoectomy/periradicular surgery for bicuspid or molars;
(B) The Division limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:
(i) Crown-to-root ratio is 50:50 or better;
(ii) The tooth is restorable without other surgical procedures; or

(iii) If loss of tooth would result in the need for removable prosthodontics;
(C) Retrograde filling (D3430) is covered only when done in conjunction with a covered apicoectomy of an anterior tooth;
(d) The Division does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service, or if the same practitioner or dental practitioner in the same group practice completed the procedure;
(e) The Division does not cover root canal therapy for third molars;
(f) The Division covers endodontics if the tooth is restorable within the OHP benefit coverage package;
(g) Apexification/recalcification procedures:
(A) The Division limits payment for apexification to a maximum of five treatments on permanent teeth only;
(B) Apexification/recalcification procedures are covered only for clients under 21 years of age or who are pregnant;
(h) Canal preparation and fitting of preformed dowel or post (D3950) should not be reported in conjunction with D2952, D2953, D2954, or D2957 by the same practitioner.
(6) PERIODONTIC SERVICES:
(a) Surgical periodontal services (includes six months routine postoperative care):
(A) D4210 and D4211 – limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia;
(B) The Division covers the following services only for clients under 21 years of age or who are pregnant:
(i) D4240, D4241, D4260 and D4261 -- allowed once every three years unless there is a documented medical/dental indication;
(ii) D4245 and D4268;
(b) Non-surgical periodontal services:
(A) D4341 and D4342 -- allowed once every two years. A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances. Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater;
(B) D4355 – allowed only once every 2 years;
(c) Other periodontal services - D4910 – limited to following periodontal therapy and allowed once every six months. For further consideration of more frequent periodontal maintenance benefits, office records must clearly reflect clinical indication, i.e., chart notes, pocket depths and radiographs;
(d) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;
(e) The Division may not reimburse for procedures identified by the following codes if performed on the same date of service:
(A) D1110 (Prophylaxis – adult);
(B) D1120 (Prophylaxis – child);
(C) D4210 (Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant);
(D) D4211 (Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant);
(E) D4260 (Osseous surgery, including flap entry and closure – four or more contiguous teeth or bounded teeth spaces per quadrant);

(F) D4261 (Osseous surgery, including flap entry and closure – one to three contiguous teeth or bounded teeth spaces per quadrant);
(G) D4341 (Periodontal scaling and root planning – four or more teeth per quadrant);
(H) D4342 (Periodontal scaling and root planning – one to three teeth per quadrant);
(I) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and
(J) D4910 (Periodontal maintenance).
(7) REMOVABLE PROSTHODONTIC SERVICES:
(a) Clients age 16 years and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140);
(b) The Division limits full dentures for non-pregnant clients age 21 and older to only those clients who are recently edentulous:
(A) For the purposes of this rule:
(i) "Edentulous" means all teeth removed from the jaw for which the denture is being provided; and
(ii) "Recently edentulous" means the most recent extractions from that jaw occurred within six months of the delivery of the final denture (or, for fabricated prosthetics, the final impression) for that jaw;
(B) See OAR 410-123-1000 for detail regarding billing fabricated prosthetics;
(c) The fee for the partial and full dentures includes payment for adjustments during the six-month period following delivery to clients;
(d) Resin partial dentures (D5211-D5212):
(A) The Division may not approve resin partial dentures if stainless steel crowns are used as abutments;
(B) The client must have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;
(C) The dental practitioner must note the teeth to be replaced and teeth to be clasped when requesting prior authorization (PA);
(e) Replacement of removable partial or full dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:
(A) For clients at least 16 years and under 21 years of age or who are pregnant - the Division shall replace full or partial dentures once every ten years, only if dentally appropriate. This does not imply that replacement of dentures or partials must be done once every ten years, but only when dentally appropriate;
(B) For non-pregnant clients 21 years of age and older - the Division may not cover replacement of full dentures, but shall cover replacement of partial dentures once every 10 years only if dentally appropriate;
(C) The ten year limitations apply to the client regardless of the client's OHP or Dental Care Organization (DCO) enrollment status at the time client's last denture or partial was received. For example: a client receives a partial on February 1, 2002, and becomes a FFS OHP client in 2005. The client is not eligible for a replacement partial until February 1, 2012. The client gets a replacement partial on February 3, 2012 while FFS and a year later enrolls in a DCO. The client would not be eligible for another partial until February 3, 2022, regardless of DCO or FFS enrollment;

(D) Replacement of partial dentures with full dentures is payable ten years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant replacement;
(f) The Division limits reimbursement of adjustments and repairs of dentures that are needed beyond six months after delivery of the denture as follows for non-pregnant clients 21 years of age and older:
(A) A maximum of 4 times per year for:
(i) Adjusting complete and partial dentures, per arch (D5410-D5422);
(ii) Replacing missing or broken teeth on a complete denture – each tooth (D5520);
(iii) Replacing broken tooth on a partial denture – each tooth (D5640);
(iv) Adding tooth to existing partial denture (D5650);
(B) A maximum of 2 times per year for:
(i) Repairing broken complete denture base (D5510);
(ii) Repairing partial resin denture base (D5610);
(iii) Repairing partial cast framework (D5620);
(iv) Repairing or replacing broken clasp (D5630);
(v) Adding clasp to existing partial denture (D5660);
(g) Denture rebase procedures:
(A) Rebase should only be done if a reline may not adequately solve the problem. The Division limits payment for rebase to once every three years;
(B) The Division may make exceptions to this limitation in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing;
(h) Denture reline procedures:
(A) The Division limits payment for reline of complete or partial dentures to once every three years;
(B) The Division may make exceptions to this limitation under the same conditions warranting replacement;
(C) Laboratory relines:
(i) Are not payable prior to six months after placement of an immediate denture; and
(ii) Are limited to once every three years;
(i) Interim partial dentures (D5820-D5821, also referred to as "flippers"):
(A) Are allowed if the client has one or more anterior teeth missing; and
(B) The Division shall reimburse for replacement of interim partial dentures once every 5 years, but only when dentally appropriate;
(j) Tissue conditioning:
(A) Is allowed once per denture unit in conjunction with immediate dentures; and
(B) Is allowed once prior to new prosthetic placement.
(8) MAXILLOFACIAL PROSTHETIC SERVICES:
(a) Maxillofacial prosthetics are medical services. Refer to the "Covered and Non-Covered Dental Services" document and OAR 410-123-1220;

(b) Bill for maxillofacial prosthetics using the professional (CMS-1500, DMAP 505 or 837P) claim format:
(A) For clients receiving services through an FCHP or PCO, bill maxillofacial prosthetics to the FCHP or PCO;
(B) For clients receiving medical services through FFS, bill the Division.
(9) ORAL SURGERY SERVICES:
(a) Bill the following procedures in an accepted dental claim format using CDT codes:
(A) Procedures that are directly related to the teeth and supporting structures that are not due to a medical, including such procedures performed in an ambulatory surgical center (ASC) or an inpatient or outpatient hospital setting;
(B) Services performed in a dental office setting (including an oral surgeon's office):
(i) Such services include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs and follow-up visits;
(ii) Refer to OAR 410-123-1160 for any PA requirements for specific procedures;
(b) Bill the following procedures using the professional claim format and the appropriate American Medical Association (AMA) CPT procedure and ICD-9 diagnosis codes:
(A) Procedures that are a result of a medical condition (i.e., fractures, cancer);
(B) Services requiring hospital dentistry that are the result of a medical condition/diagnosis (i.e., fracture, cancer);
(c) Refer to the "Covered and Non-Covered Dental Services" document to see a list of CDT procedure codes on the HSC Prioritized List that may also have CPT medical codes. See OAR 410-123-1220. The procedures listed as "medical" on the table may be covered as medical procedures, and the table may not be all-inclusive of every dental code that has a corresponding medical code;
(d) For clients enrolled in a DCO, the DCO is responsible for payment of those services in the dental plan package;
(e) Oral surgical services performed in an ASC or an inpatient or outpatient hospital setting:
(A) Require PA;
(B) For clients enrolled in a FCHP, the facility charge and anesthesia services are the responsibility of the FCHP. For clients enrolled in a PCO, the outpatient facility charge (including ASCs) and anesthesia are the responsibility of the PCO. Refer to the current Medical Surgical Services administrative rules in OAR chapter 410 – division 130 for more information;
(C) If a client is enrolled in a FCHP or a PCO, it is the responsibility of the provider to contact the FCHP or the PCO for any required authorization before the service is rendered;
(f) All codes listed as "by report" require an operative report;
(g) The Division covers payment for tooth re-implantation only in cases of traumatic avulsion where there are good indications of success;
(h) Biopsies collected are reimbursed as a dental service. Laboratory services of biopsies are reimbursed as a medical service;
(i) The Division does not cover surgical excisions of soft tissue lesions (D7410 – D7415);
(j) Extractions -- Includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service;
(k) Surgical extractions:
(A) Include local anesthesia and routine post-operative care;

(B) The Division limits payment for surgical removal of impacted teeth or removal of residual tooth roots to treatment for only those teeth that have acute infection or abscess, severe tooth pain, and/or unusual swelling of the face or gums;
(C) The Division does not cover alveoloplasty in conjunction with extractions (D7310 and D7311) separately from the extraction;
(D) The Division covers alveoplasty not in conjunction with extractions (D7320) only for clients under 21 years of age or who are pregnant.
(10) ORTHODONTIA SERVICES:
(a) The Division limits orthodontia services and extractions to eligible clients:
(A) With the ICD-9-CM diagnosis of:
(i) Cleft palate; or
(ii) Cleft palate with cleft lip; and
(B) Whose orthodontia treatment began prior to 21 years of age; or
(C) Whose surgical corrections of cleft palate or cleft lip were not completed prior to age 21;
(b) PA is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate/cleft lip must be included in the client's record and a copy sent with the PA request;
(c) Documentation in the client's record must include diagnosis, length and type of treatment;
(d) Payment for appliance therapy includes the appliance and all follow-up visits;
(e) Orthodontists evaluate orthodontia treatment for cleft palate/cleft lip as two phases. Stage one is generally the use of an activator (palatal expander) and stage two is generally the placement of fixed appliances (banding). The Division shall reimburse each phase individually (separately);
(f) The Division shall pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist must refund to the Division any unused amount of payment, after applying the following formula: Total payment minus $300.00 (for banding) multiplied by the percentage of treatment remaining;
(g) The Division shall use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;
(h) As long as the orthodontist continues treatment, the Division may not require a refund even though the client may become ineligible for medical assistance sometime during the treatment period;
(i) Code:
(A) D8660 -- PA required (reimbursement for required orthodontia records is included);
(B) Codes D8010-D8999 -- PA required.
(11) ADJUNCTIVE GENERAL AND OTHER SERVICES:
(a) Fixed partial denture sectioning (D9120) is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment;
(b) Anesthesia:
(A) Only use general anesthesia or IV sedation for those clients with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure (D9220, D9221, D9241 and D9242);
(B) The Division reimburses providers for general anesthesia or IV sedation as follows:
(i) D9220 or D9241: For the first 30 minutes;

(ii) D9221 or D9242: For each additional 15-minute period, up to three hours on the same day of service. Each 15-minute period represents a quantity of one. Enter this number in the quantity column;
(C) The Division reimburses administration of Nitrous Oxide (D9230) per date of service, not by time;
(D) Oral pre-medication anesthesia for conscious sedation (D9248):
(i) Limited to clients under 13 years of age;
(ii) Limited to four times per year;
(iii) Includes payment for monitoring and Nitrous Oxide; and
(iv) Requires use of multiple agents to receive payment;
(E) Upon request, providers must submit a copy of their permit to administer anesthesia, analgesia and/or sedation to the Division;
(F) For the purpose of Title XIX and Title XXI, the Division limits payment for code D9630 to those oral medications used during a procedure and is not intended for "take home" medication;
(c) The Division limits reimbursement of house/extended care facility call (D9410) only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience;
(d) Office visit for observation (D9430):
(A) Is covered only for clients under 21 years of age or who are pregnant; and
(B) The Division reimburses a maximum of three visits per year;
(e) Oral devices/appliances (E0485, E0486):
(A) These may be placed or fabricated by a dentist or oral surgeon, but are considered a medical service;
(B) Bill the Division or the FCHP/PCO for these codes using the professional claim format.
Stat. Auth.: ORS 409.050, 414.065, and 414.707
Stats. Implemented: ORS 414.065 and 414.707

410-123-1540
Citizen/Alien-Waived Emergency Medical
(1) The Citizen/Alien-Waived Emergency Medical (CAWEM) program provides treatment of emergency medical conditions, including delivery of newborns. CAWEM is defined in OAR 410-120-0000 and further explained in OAR 410-120-1210 of the Division of Medical Assistance Programs (Division) General Rules:
(a) People covered under the CAWEM program are NOT Oregon Health Plan (OHP) clients. They DO NOT receive the OHP Plus or Standard Benefit Packages and ARE NOT enrolled into managed care plans;
(b) Refer to General Rules 410-120-1140 (Verification of Eligibility) for details regarding verifying client eligibility for services;
(c) Providers must bill emergency services provided for anyone eligible under the CAWEM program directly to the Division;
(d) Dental services provided outside of an emergency department hospital setting are not covered for CAWEM clients. See OAR 410-120-1210.

(2) Children's Health Insurance Program (CHIP) Pilot project prenatal coverage (Benefit Package identifier - CWX):
(a) Eligible pregnant women residing in the participating pilot counties receive expanded services as detailed in General Rules Program OAR 410-120-0030, which includes dental services that are covered for OHP Plus pregnant clients;
(b) This population is exempt from managed care enrollment and providers must bill the Division directly for dental services provided.
Stat. Auth.: ORS 409.050, 414.065
Stats. Implemented: ORS 414.065