5160-5-01 **Dental services.**

(A) This rule sets forth provisions governing payment for professional, non-institutional dental services. Provisions governing payment for dental services performed as the following service types are set forth in the indicated part of the Administrative Code:

(1) Hospital services, Chapter 5160-2 ~~of the Administrative Code~~;

(2) Nursing facility services, Chapter 5160-3 ~~of the Administrative Code~~;

(3) Intermediate care facility services, Chapter 5123:2-7 ~~of the Administrative Code;~~

(4) Federally qualified health center services, Chapter 5160-28 ~~of the Administrative Code;~~

(5) Ambulatory surgery center services, Chapter 5160-22; and

(6) Telehealth services, rule 5160-1-18 ~~of the Administrative Code~~.

(B) Definitions.

(1) "Metropolitan statistical area (MSA)" has the same meaning as in 40 C.F.R. 58.1 (~~-~~October 1, ~~2020~~ 2021).

(2) "Non-rural county" is a county to which the definition of rural county does not apply.

(3) "Rural county" is a county for which either of the following criteria is satisfied:

(a) The county is not located within a MSA; or

(b) At least seventy-five per cent of the population of the county lives outside the urban areas within the county.

(C) Providers of dental services.

(1) Rendering providers. The following eligible medicaid providers may render a dental service:

(a) A dentist practicing in Ohio;

(b) A dental resident acting within their licensure and scope of practice; or

(c) A dentist practicing in a state other than Ohio who meets the requirements established by the dental examining board in that state.

(2) Billing providers. The following eligible medicaid providers may receive medicaid payment for submitting a claim for a dental service:

(a) A dentist;

(b) A professional dental group; or

(c) A fee-for-service clinic.

(D) Coverage policies for dental services are set forth in appendix A to this rule.

(E) Other conditions.

(1) Dental services are subject to a copayment of three dollars per date of service per provider unless the patient is excluded from the copayment requirement pursuant to rule 5160-1-09 of the Administrative Code.

(2) For an item that requires multiple fittings and special construction (e.g., dentures), the first visit date is the date of service for purposes of prior authorization or claim submission. Payment for the item will not be made, however, until it has been delivered to the patient.

(3) Additional documentation requirements apply to dental services rendered to an individual living in a supervised residence such as a long-term care facility (LTCF).

(a) Whenever a provider updates an individual's medical or dental history, diagnosis, prognosis, or treatment plan, the provider is to keep a copy on file and send a copy of the information to the staff of the residence for inclusion in the individual's file.

(b) After a request for treatment has been signed by the individual, the individual's authorized representative, or the ~~individual's attending physician~~ practitioner responsible for the individual's care, the provider is to keep a copy on file and send a copy to the staff of the residence.

(c) For services that require prior authorization (PA), a copy of the signed request for treatment is to be submitted with the PA request along with any other required documentation.

(d) A prior authorization request submitted for complete or partial dentures for a resident of a long-term care facility is to be accompanied by the following documents:

(i) A copy of the resident's most recent nursing care plan;

(ii) A copy of a consent form signed by the resident or the resident's authorized representative; and

(iii) A dentist's signed statement describing the oral examination and assessing the resident's ability to wear dentures.

(F) Payment of claims.

(1) For a covered dental service that is identified by a current dental terminology (CDT) code, the following payment amounts apply:

(a) For a service rendered by a provider whose office address (specified in the provider agreement) is in a non-rural Ohio county or a county outside Ohio, payment is the lesser of the submitted charge or the amount listed in appendix DD to rule 5160-1-60 of the Administrative Code.

(b) For a service rendered by a provider whose office address is in a rural Ohio county, payment is the lesser of the submitted charge or one hundred five per cent of the amount listed in appendix DD to rule 5160-1-60 of the Administrative Code.

(2) For a covered dental service that is identified by a current procedural terminology (CPT) code, such as oral surgery, payment is the lesser of the submitted charge or the amount listed in appendix DD to rule 5160-1-60 of the Administrative Code, regardless of whether the service is provided in a rural or non-rural county.

Effective:

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Certification

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