CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Dental services

Rule Number(s):

SUBJECT TO BUSINESS IMPACT ANALYSIS:

To Be Rescinded: Rules 5160-5-01, 5160-5-02, 5160-5-03, 5160-5-05, 5160-5-06, 5160-5-07, 5160-5-08, 5160-5-09, 5160-5-10 with appendix A (form ODM 03630), 5160-5-11

New: Rule 5160-5-01 with appendices A and B

NOT SUBJECT TO BUSINESS IMPACT ANALYSIS, INCLUDED FOR INFORMATION ONLY:

To Be Rescinded: Rule 5160-5-04

New: Form ODM 03630

Date: September 21, 2015

Rule Type:

- ☑ New
- ☐ Amended
- ☑ 5-Year Review
- ☑ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rules in Chapter 5160 of the Ohio Administrative Code set forth Medicaid coverage and payment policies for dental services and related oral health services.

   5160-5-01, "Dental program: general and co-payment provisions"
   5160-5-02, "Dental program: covered diagnostic services and limitations"
   5160-5-03, "Dental program: covered tests and laboratory examinations and limitations"
   5160-5-04, "Dental program: covered preventive services and limitations"
   5160-5-05, "Dental program: covered restorative services and limitations"
   5160-5-06, "Dental program: covered endodontic services and limitations"
   5160-5-07, "Dental program: covered periodontic services and limitations"
   5160-5-08, "Dental program: covered removable prosthodontic services and limitations"
   5160-5-09, "Dental program: covered oral surgery services and limitations"
   5160-5-10, "Dental program: covered orthodontic services and limitations"
   5160-5-11, "Dental program: other covered services and limitations"

   These existing rules are being proposed for rescission, and their provisions are being consolidated into a single new rule.

   New rule 5160-5-01, "Dental services," sets forth Medicaid coverage and payment policies for dental services. It includes two appendices, one that lays out coverage of services by category and one that lists maximum payment amounts by procedure.

   Several changes incorporated into the new rule are noteworthy:

   - Procedure terminology is updated. The descriptors for a number of preventive and diagnostic services are revised. In Appendix B to the new rule, new procedure codes are listed, coverage changes are noted, and one outdated local-level procedure code (Y7255) for surgical removal of a supernumerary tooth is discontinued and replaced with the current industry standard.
   - Certain longstanding program policies are codified and clarified. The first date of service, for example, may be reported on claims for items (such as dentures) that require multiple fittings, so long as the claim is not submitted until after the individual has received the item. And in instances when it is clinically appropriate for separate restorations to be performed on the same surface of the same tooth, the rule now specifies that payment may be made for such restorations performed on mandibular teeth as well as on maxillary teeth.
   - Prior authorization requirements have been removed for certain services or procedures.
   - Set payment amounts have been established for certain services or procedures that previously required manual pricing.
   - A payment increase and a rural payment fee differential have been established, based on funds appropriated in House Bill 64 of the 131st General Assembly, for dental services rendered in a rural area.

- Coverage is established for periodontal scaling and root planing services and for intravenous conscious sedation/analgesia.
- Coverage is extended to equivalent services or procedures.
- The add-on incentive payment for general anesthesia provided in an office setting is eliminated, and the maximum payment for general anesthesia as a dental service is increased by the incentive amount.
- Form ODM 03630, "Referral evaluation criteria for comprehensive orthodontic treatment," is updated and retitled "Referral evaluation for comprehensive orthodontic treatment." It will be available on the ODM web site as a standalone document rather than as a rule appendix.

2. Please list the Ohio statute authorizing the Agency to adopt this regulation.

Section 5164.02 of the Ohio Revised Code.

3. Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?
If yes, please briefly explain the source and substance of the federal requirement.

No.

4. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

These rules do not exceed federal requirements.

5. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

Medicaid rules perform several core business functions: They establish and update coverage and payment policies for medical goods and services. They set limits on the types of entities that can receive Medicaid payment for these goods and services. They publish payment formulas or fee schedules for the use of providers and the general public.

6. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

The success of these rules will be measured by the extent to which operational updates to the Medicaid Information Technology System (MITS) result in the correct payment of claims.

Development of the Regulation

7. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.
If applicable, please include the date and medium by which the stakeholders were initially contacted.

Over a period of at least a year, the following stakeholders have had the opportunity to review and shape the policies expressed in the dental services rules:

- Ohio Dental Association (ODA)
  - ODA Council on Access to Care and Public Services
  - ODA Medicaid workgroup
- Ohio Department of Health Director's Task Force on Oral Health and Access to Dental Care
- Children's Oral Health Action Team (COHAT)
- Universal Health Care Action Network (UHCAN) Ohio
- Ohio Hospital Association (OHA)
- Ohio Association of Community Health Centers (OACHC)
- The Legal Aid Society of Cleveland
- Three practicing dentists who serve as medical technical advisors (MTAs) to ODM

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

Discussions with the Ohio Dental Association (ODA), its members, and other oral health stakeholders helped to spark policy revision and development, particularly the clarification in rule of longstanding policy provisions.

Regular meetings are held with the ODA Council on Access to Care and Public Services; meetings of the ODA Medicaid work group are called as needed. Some dentists are members of both groups. ODM and ODA staff members also get in contact periodically (in person or by telephone, e-mail, or surface mail) to discuss dental industry and provider issues, concerns, and opportunities.

The Council met with ODM staff members on November 21, 2013, and on March 25, July 18, and October 31, 2014. Discussion topics included Medicaid dental services coverage and limitations, program requirements, and program policy. As a result of these meetings, rule language was drafted to incorporate updated procedure codes, to relax prior authorization (PA) requirements, and to extend coverage to "equivalent" procedure codes at the same maximum payment amounts as were applied to existing covered codes. The aim of these rule updates was to recognize changes in the practice of dentistry and to increase program participation without additional cost to the state. Coverage of periodontic scaling and root planing was also proposed.

The ODA Medicaid work group met with ODM staff members on December 11, 2013, and on March 5, 2014. The purpose of the December meeting was to follow up on previous efforts to identify new procedure codes to be considered for coverage and to continue discussion of program issues related to the pending rule revision. The March meeting focused on review of previously submitted suggestions regarding covered

services, payment amounts, clarification of current policy, and coverage of periodontic scaling and root planing.

Consensus was reached on coverage of equivalent procedure codes for currently covered services, rule language, relaxation of PA requirements, coverage of intravenous conscious sedation, and coverage of periodontic scaling and root planing. An increase in maximum payment amounts was included in the state budget as was funding for a differential payment for dental services rendered in a rural area.

ODM has had contact with other state agencies and various associations and oral health advocacy groups, such as COHAT, UHCAN Ohio, OHA, and OACHC. Many of these groups are represented on the Ohio Department of Health Director's Task Force on Oral Health and Access to Dental Care, which also includes representatives of providers, foundations, dental organizations, payers, and workforce development efforts. During 2014 the Task Force met six times; the main topic at two of these meetings was the Ohio Medicaid program, and discussion focused on eligible providers, provision of services by non-dentists, payment, and access to care.

Other advocates, providers, and lobbyists met with ODM staff members in 2013 and 2014, primarily about coverage of scaling and root planning and Medicaid payment amounts; the proposed changes to the dental services rules were also discussed. There was general support for coverage of periodontic scaling and root planing services. An increase in payment amounts was proposed as a budget initiative, and draft rule language was further refined.

ODM staff members met with representatives of the Ohio Dental Board on several occasions. The main focus was scope-of-practice questions, provider enrollment, and coverage of dental services. The pending rule draft and program initiatives were also discussed. The Board representatives provided comment during these meetings but did not give any follow-up input.

From March 2014 through October 2014, the MTAs thoroughly reviewed drafts of the new rule and its appendices, made suggestions for clarification, and recommended additional policy revisions. All but a few of these modifications were incorporated. The number of individual changes was large, but the types were relatively limited:

- Clarification of phrasing (e.g., use of '21 or older' instead of 'older than 20')
- Additional or clarification of coverage criteria or restrictions (e.g., denial of payment for both bitewing and panoramic images)
- Correction of overly specific provisions (e.g., extension of prior authorization policy for porcelain/metal crowns to all crowns)
- Alignment of wording in rule body and appendix (e.g., requirements for the provision of dentures to a resident of a long-term care facility)
- Additional description of included services (e.g., specification of a six-month follow-up period after denture relining)
- Initiation or discontinuation of requirement for prior authorization of payment (e.g., changes in PA status of certain oral surgery services)
- Clarification of scope of coverage and removal of non-covered procedures/services (e.g., specification that a space maintainer must be a passive device, statement that removal of lateral exostoses is covered for both the maxilla and the mandible, deletion of nitrous oxide inhalation from the coverage list)
- Correction of errors in the payment schedule

The Legal Aid Society of Cleveland objected that the provisions in the initial draft of the rule concerning orthodontia did not meet the standards of federal law defining the duty of a state Medicaid agency to cover services for children, and it proffered written guidance from the federal Centers for Medicare and Medicaid (CMS) in support of this position. After reviewing the CMS documents, ODM incorporated most of the Society's suggestions into the rule, particularly the use of psychosocial as well as medical criteria in determining whether to authorize payment for orthodontia.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   Utilization and expenditure data drawn from ODM's Quality Decision Support System were used in projecting the fiscal impact of the proposed changes.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    These rules involve the coverage of and payment for dental procedures. Whatever the policy may be, the form of the rule is the same; no alternative is readily apparent.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    The concept of performance-based rule-making does not apply to these items and services.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    Rules involving Medicaid providers are housed exclusively within agency 5160 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. It is clear which rules apply to which type of provider and item or service; in this instance, there was no duplication.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    The policies set forth in these rules will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the applicable rule. They will therefore be automatically and consistently applied by the ODM's electronic claim-payment system whenever an appropriate provider submits a claim for an applicable service.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

c. Quantify the expected adverse impact from the regulation.

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a. Changes to these rules affect dentists and other eligible Medicaid providers of dental services, such as fee-for-service clinics.

b. These rules impose no license fees or fines. The existing rules and new rule indicate that no eligible provider may receive payment without a valid Medicaid provider agreement. Both the existing rules and new rule specify that participating practitioners must hold a current license and, as appropriate, maintain documentation that the services were provided and the medical necessity of the services. The documentation of medical necessity and the services provided helps to substantiate the appropriateness of the services rendered to Medicaid-eligible individuals. These requirements are consistent with professional standards, and are imposed for program integrity purposes.

c. The adverse impact lies in the time needed to complete documentation of medical necessity and the services provided. Completing documentation of medical necessity and the services provided whether or not a prior authorization request is required takes between five and thirty minutes of provider staff time. This estimate is based on the personal experience of practicing dentists, including the ODM medical technical advisors (MTAs). The wage cost depends on who performs the task. The median statewide hourly wage for a billing clerk, according to Labor Market Information (LMI) data published by the Ohio Department of Job and Family Services, is $16.10; for a dentist, it is $87.21. Adding 30% for fringe benefits brings these figures to $20.93 and $113.37. So generating a necessary document costs between $1.75 (five minutes at $20.93 per hour) and $56.69 (thirty minutes at $113.37 per hour).

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The documentation requirements spelled out in these rules are an effective tool for preventing fraud, waste, and abuse and for promoting quality and cost-effectiveness; they help to ensure that the Ohio Medicaid program pays for dental services that are most appropriate to the needs of the person who will receive them.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

These rules outline actions all providers must take in order to receive Medicaid payment. They do not set forth requirements for engaging in business, and no exception is made on the basis of an entity's size.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

These rules impose no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a "trading partner") can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

Policy questions may be directed via e-mail to the Non-Institutional Benefit Management section of ODM's policy bureau, at noninstitutional_policy@medicaid.ohio.gov.

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;

(2) Nursing facility services, Chapter 5160-3;

(3) Intermediate care facility services, Chapter 5123:2-7; and

(4) Federally qualified health center services, Chapter 5160-28.

(B) Definitions.

(1) "Metropolitan statistical area (MSA)" has the same meaning as in 40 C.F.R. 58.1 (July 1, 2015).

(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; or

(b) 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 must 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, the provider must 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 must 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 must 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 B to this rule.

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

(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.

Replaces: 5160-5-01, 5160-5-02, 5160-5-03, 5160-5-04, 5160-5-05, 5160-5-06, 5160-5-07, 5160-5-08, 5160-5-09, 5160-5-10, 5160-5-11

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.20, 5164.02
Prior Effective Dates:	04/07/1977, 12/21/1977, 09/02/1985, 05/09/1986, 01/04/1988, 02/01/1988, 11/15/1993, 08/01/1995, 12/29/1995 (Emer), 03/21/1996, 01/01/2000, 01/02/2000, 01/02/2002, 10/01/2003, 01/01/2006, 12/29/2006 (Emer), 03/29/2007, 07/01/2008, 12/31/2008 (Emer), 03/31/2009, 01/01/2010, 12/30/2010 (Emer), 03/30/2011, 08/02/2011, 12/31/2012 (Emer), 03/28/2013

Appendix A to rule 5160-5-01

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
CLINICAL ORAL EXAMINATION			
Comprehensive oral evaluation – A thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, it includes a dental and medical history and a general health assessment. It may encompass such matters as dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions, periodontal charting, tissue anomalies, and oral cancer screening. Interpretation of information may require additional diagnostic procedures, which should be reported separately.	1 per 5 years per provider per patient	No payment is made for a comprehensive oral evaluation performed in conjunction with a periodic oral evaluation.	No
Periodic oral evaluation – An evaluation performed to determine any changes in dental and medical health since a previous comprehensive or periodic evaluation, it may include periodontal screening. Interpretation of information may require additional diagnostic procedures, which should be reported separately.	Patient younger than 21: 1 per 180 days Patient 21 or older: 1 per 365 days	No payment is made for a periodic oral evaluation performed in conjunction with a comprehensive oral evaluation nor within 180 days after a comprehensive oral evaluation.	No
Limited oral evaluation, problem-focused – An evaluation limited to a specific oral health problem or complaint, it includes any necessary palliative treatment. Interpretation of information may require additional diagnostic procedures, which should be reported separately.		No payment is made if the evaluation is performed solely for the purpose of adjusting dentures, except as specified in Chapter 5160-28 of the Administrative Code. No payment is made for a limited oral evaluation performed in conjunction with other dental procedures except images taken on the same date of service.	No
Comprehensive periodontal evaluation, new or established patient	1 per 365 days	No payment is made for a comprehensive periodontal evaluation performed in conjunction with either a comprehensive oral evaluation or a periodic oral evaluation.	Yes, for a patient younger than 21

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
DIAGNOSTIC IMAGING, INCLUDING INTERPRETATION A diagnostic image may be submitted either as a tangible object or as a digital representation. All images must be of diagnostic quality, properly exposed, clearly focused, clearly readable, properly mounted (if applicable), and free from defect for the relevant area of the mouth. Each image submitted must bear the name of the patient, the date on which the image was taken, and the name of the provider or of the provider's office. A periapical image must completely show the periodontal ligament, the crown, and the root structure in its entirety. A bitewing image must completely show the crowns with little or no overlapping. A bitewing image cannot be substituted for a periapical image when endodontic treatment is necessary. A panoramic image must completely show the crowns with little or no overlapping, the roots, the bony tissues, and the soft tissues in both arches.			
Intraoral images, complete series (including bitewings)	1 per 5 years per provider	Consisting of at least 12 images, the series must include all periapical, bitewing, and occlusal images necessary for diagnosis.	Yes, for frequency greater than 1 per 5 years
Intraoral periapical image, first Intraoral periapical image, each additional Intraoral occlusal image			No
Extraoral image, first		An extraoral image is allowed as an adjunct to complex treatment.	No
Bitewing image, one	1 per 6 months		No
Bitewing images, two Bitewing images, three Bitewing images, complete series (at least four images)	1 per 6 months (recommended interval from 6 to 24 months for a complete series)	Payment may be made only if permanent second molars have erupted. No payment is made for multiple bitewing images taken in conjunction with a panoramic image or complete series of images.	No
Panoramic image	Patient younger than 6: PA Patient 6 or older: 1 per 5 years	No payment is made for a panoramic image taken in conjunction with a complete series of images nor within 5 years after a complete series of images.	Yes, for a patient younger than 6 Yes, for frequency greater than 1 per 5 years Yes, for provision within 5 years after a complete series of images
Cephalometric image			No
Diagnostic image in conjunction with orthodontic treatment			No
Temporomandibular joint images, four to six images, including submission of patient history and treatment plan			No

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
TESTS AND LABORATORY EXAMINATIONS A diagnostic cast may be submitted either as a tangible object or as a digital representation.			
Biopsy of oral tissue, hard (bone, tooth)			No
Biopsy of oral tissue, soft (all others)			No
Diagnostic cast		Payment may be made only in conjunction with a treatment that requires a diagnostic cast. A cast may be either a tangible object or a digital representation.	No

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
PREVENTIVE SERVICES			
Dental prophylaxis, adult (14 or older), including necessary scaling or polishing to remove coronal plaque, calculus, and stains of transitional or permanent teeth	Patient younger than 21: 1 per 180 days Patient 21 or older: 1 per 365 days	No payment is made for prophylaxis performed in conjunction with gingivectomy, gingivoplasty, or scaling and root planing.	No
Dental prophylaxis, child (younger than 14), including necessary scaling or polishing to remove coronal plaque, calculus, and stains of primary or transitional teeth	1 per 180 days	No payment is made for prophylaxis performed in conjunction with gingivectomy, gingivoplasty, or scaling and root planing.	No
Topical fluoride treatment, including sodium fluoride, stannous fluoride, or acid phosphate fluoride applied as a foam, gel, varnish, or in-office rinse Topical application of fluoride varnish Topical application of fluoride	1 per 180 days	Coverage is limited to patients younger than 21. Use of a polishing compound that incorporates fluoride as part of prophylaxis is not considered to be a separate topical fluoride treatment. Topical application of fluoride to a tooth being prepared for restoration, application of fluoride by the patient, and application of sodium fluoride as a desensitizing agent are not covered fluoride treatments.	No
Sealant		Coverage is limited to patients younger than 18. Pit and fissure sealant may be applied to previously unrestored areas of permanent first and second molars.	No
Space maintainer, fixed unilateral Space maintainer, fixed bilateral Space maintainer, removable unilateral Space maintainer, removable bilateral		Coverage is limited to patients younger than 21. Payment may be made only for a passive type of space maintainer.	No

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
RESTORATIVE SERVICES Payment for a restorative service includes tooth preparation and any base or liner (e.g., copalite or calcium hydroxide) placed beneath the restoration. Payment for a restorative service includes necessary local anesthesia. Payment for a crown includes the provision of a temporary crown. Payment for multiple restorations performed on the same tooth on the same date of service are made as though the restorations were done separately (up to a maximum of three). Only one occlusal restoration, whether performed alone or in combination with restoration of another surface, is allowed on any posterior tooth except maxillary molars. On maxillary molars, not more than two occlusal restorations are allowed, whether performed alone or in combination with restoration of another surface.			
Amalgam, one surface, primary or permanent Amalgam, two surfaces, primary or permanent Amalgam, three surfaces, primary or permanent Amalgam, four or more surfaces, primary or permanent		Restoration includes polishing. If a tooth has decay on three surfaces on which separate restoration can be performed, then separate payment may be made for each restoration performed in accordance with accepted standards of dental practice. Preventive restoration is not covered.	No
Pin retention, in addition to amalgam restoration	3 pins per tooth		No
Resin-based composite, one surface, anterior Resin-based composite, two surfaces, anterior Resin-based composite, three surfaces, anterior Resin-based composite, four or more surfaces, anterior, or involving incisal angle Resin-based composite, one surface, posterior Resin-based composite, two surfaces, posterior Resin-based composite, three surfaces, posterior Resin-based composite, four or more surfaces, posterior		Payment includes any necessary acid etching. Resin-based composite is permitted for all restorations of anterior teeth and for class I, II, or V restoration of posterior teeth. Single-surface restoration must involve repair of decay that extends into the dentin. If a tooth has decay on three surfaces on which separate restoration can be performed, then separate payment may be made for each restoration performed in accordance with accepted standards of dental practice. Preventive restoration is not covered.	No
Pin retention, in addition to resin-based composite restoration	3 pins per tooth		No
Crown, porcelain fused to noble metal Crown, porcelain fused to predominately base metal Crown, porcelain/ceramic substrate		A fused porcelain crown may be covered for anterior teeth only. A periapical image of the involved tooth must be submitted with each PA request.	Yes

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
Crown, anterior resin-based composite Crown, prefabricated stainless steel, primary tooth Crown, prefabricated stainless steel, permanent tooth Crown, prefabricated stainless steel with resin window (open face crown with aesthetic resin facing or veneer) Crown, prefabricated esthetic coated stainless steel, primary tooth		A stainless steel crown is permitted only for teeth on which multisurface restorations are needed and amalgam restorations and other materials have a poor prognosis. An anterior resin-based composite crown may be covered only for a patient younger than 21. An anterior resin-based composite crown or a stainless steel crown with resin window may be covered for anterior teeth only. Payment for a crown with resin window includes any necessary restoration.	No
Indirectly fabricated post and core in addition to crown Prefabricated post and core in addition to crown		PA may be granted only for endodontically treated permanent anterior teeth with sufficient tooth structure to support a crown. A periapical image of the involved tooth must be submitted with each PA request.	Yes

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
ENDODONTIC SERVICES Endodontic therapy is covered only when the overall health of the teeth and periodontium is good except for the indicated tooth or teeth. Decay must be above the bone level. The patient must experience chronic pain (as evidenced by sensitivity to hot or cold or through percussion or palpation), or there must be a fistula present that is associated with the tooth infection or chronic systemic infection. Images must be clearly readable labeled, and properly mounted, and must show periapical radiolucency or widening of the periodontal ligament. If pathology is not visible on an image, then the need for endodontic treatment must be substantiated by clinical documentation. Payment includes all diagnostic tests, evaluations, images, and postoperative treatment.			
Therapeutic pulpotomy and pulpal therapy		Coverage is limited to patients younger than 21. No separate payment is made when these procedures are performed in conjunction with root canal therapy. Separate payment may be made for restoration.	No
Endodontic (complete root canal) therapy, excluding final restoration, anterior tooth Endodontic (complete root canal) therapy, excluding final restoration, bicuspid Endodontic (complete root canal) therapy, excluding final restoration, molar		Coverage is limited to permanent teeth. Payment for these procedures includes all diagnostic tests, evaluations, necessary images, and postoperative treatment.	No
Apicoectomy/periradicular services		Coverage is limited to permanent teeth. All available images of the mouth must be maintained in the patient's clinical record. A periapical view of the tooth and the area involved must be included.	No
Apexification/recalcification/pulpal regeneration (apical closure or calcific repair of perforations, root resorption, pulp space disinfection, etc.), initial visit Apexification/recalcification/pulpal regeneration (apical closure or calcific repair of perforations, root resorption, pulp space disinfection, etc.), interim medication replacement Apexification/recalcification/pulpal regeneration (apical closure or calcific repair of perforations, root resorption, pulp space disinfection, etc.), final visit		Apical closure does not include endodontic (root canal) therapy. Payment for these procedures includes necessary images.	No

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
PERIODONTIC SERVICES			
Gingivectomy or gingivoplasty, one to three contiguous teeth per quadrant Gingivectomy or gingivoplasty, four or more contiguous teeth or tooth-bounded spaces per quadrant		Coverage is limited to correction of severe hyperplasia or hypertrophic gingivitis. Complete images of the mouth and diagnostic casts must be submitted with each PA request.	Yes
Periodontal maintenance	1 per 365 days	No payment is made for periodontic maintenance if no scaling or root planing was performed within the previous 24 months. No payment is made for periodontic maintenance performed in conjunction with prophylaxis nor within 30 days of scaling and root planing.	No
Periodontal scaling and root planing, one to three teeth per quadrant Periodontal scaling and root planing, four or more teeth per quadrant	1 per 24 months per quadrant	No payment is made for scaling and root planing performed in conjunction with oral prophylaxis, gingivectomy, or gingivoplasty. The required documentation of the need for periodontal scaling and root planing must include the following items: (1) A periodontal treatment plan and history. (2) A completed copy of an ADA periodontal chart or the equivalent that exhibits pocket depths with all six surfaces charted. (3) Current, properly mounted, labeled, and readable periapical images of the mouth and posterior bitewing images showing evidence of root surface calculus and bone loss, indicating a true periodontic disease state.	Yes

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
PROSTHODONTIC SERVICES A prescription for dentures must be based on the total condition of the mouth, the patient's ability to adjust to dentures, and the patient's desire to wear dentures. Natural teeth that have healthy bone, are sound, and do not have to be extracted must not be removed. The provider is responsible for constructing a functional denture. Payment for a denture or denture service includes all necessary follow-up corrections and adjustments for a period of six months. No payment is made if an evaluation is performed solely for the purpose of adjusting dentures, except as specified in Chapter 5160-28 of the Administrative Code. A preformed denture with teeth already mounted (i.e., a denture module for which no impression is made of the patient) is not covered. When a prior authorization request is submitted for complete or partial dentures for a resident of a long-term care facility, it must be accompanied by the following documents: (1) A copy of the resident's most recent nursing care plan; (2) A copy of a consent form signed by the resident or the resident's authorized representative; and (3) A dentist's signed statement describing the oral examination and assessing the resident's ability to wear dentures. Authorization for a denture will not be granted if dentures made for the patient in the recent past were unsatisfactory because of irremediable psychological or physiological reasons. Relining is the readaptation of a denture to the patient's present oral tissues in accordance with accepted dental practice standards and procedures. The denture must be processed and finished with materials chemically compatible with the existing denture base. Chairside self-curing materials are not allowed.			
Complete denture, maxillary Complete denture, mandibular	1 per 8 years, except in very unusual circumstances	Complete extractions must be deferred until authorization to construct the denture has been given, except in an emergency. The immediate provision of dentures will not be authorized except in very unusual circumstances. If the patient still has natural teeth, then a panoramic image or complete series of images, properly mounted, labeled, and readable, must be submitted with each PA request. No pre-treatment image is necessary if the patient had no natural teeth before the first visit with the treating dentist.	Yes

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
Partial denture, cast metal framework with resin base (including conventional clasps, rests, and teeth), maxillary Partial denture, cast metal framework with resin base (including conventional clasps, rests, and teeth), mandibular Partial denture, resin base (including conventional clasps, rests, and teeth), maxillary Partial denture, resin base (including conventional clasps, rests, and teeth), mandibular	1 per 8 years, except in very unusual circumstances	PA may be granted when either (1) the absence of several teeth in the arch severely impairs the ability to chew or (2) the absence of anterior teeth affects the appearance of the face. A partial denture with a resin base may be covered only for a patient younger than 19. A panoramic image or complete series of images, properly mounted, labeled, and readable, must be submitted with each PA request.	Yes
Repair of base, complete denture Replacement of missing or broken tooth, complete denture Repair of resin base, partial denture Repair of cast metal framework, partial denture Replacement of missing or broken tooth, partial denture Repair or replacement of broken clasp, partial denture Addition of tooth, partial denture Addition of clasp, partial denture			No
Relining, complete denture, maxillary Relining, complete denture, mandibular Relining, partial denture, maxillary Relining, partial denture, mandibular	1 per 4 years and no sooner than 4 years after initial construction, except in unusual circumstances	All relining procedures include post-delivery care for six months.	No

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
ORAL SURGERY A tooth should be removed only if it cannot be saved because it is too deteriorated, is too poorly supported by alveolar bone, or is subject to some pathological condition. Except in an emergency, an extraction that renders a patient toothless must be deferred until authorization to construct a denture has been granted. The extraction of an impacted tooth is authorized only when conditions arising from such an impaction warrant removal. The prophylactic removal of an asymptomatic tooth is covered only when at least one adjacent tooth is symptomatic. Payment for extraction includes necessary local anesthesia, suturing, and routine postoperative care. Unless specific codes are required, surgery procedure codes from either the CPT or the CDT may be reported on claims for oral surgery services. Regardless of the procedure code used, all claims must be submitted in the appropriate format.			
Extraction, erupted tooth or exposed root (elevation, forceps removal, or both)	1 per tooth	No separate payment is made for multiple roots.	No
Surgical removal of impacted tooth, soft tissue Surgical removal of impacted tooth, partially bony	1 per tooth		No, for removal of an impacted third molar, soft tissue Yes, otherwise No, for partially bony impaction
Surgical removal of impacted tooth, completely bony Surgical removal of impacted tooth, completely bony, with complications	1 per tooth	An image of the impaction must be maintained in the patient's clinical record.	Yes
Surgical removal of a residual tooth root (cutting procedure)	1 per tooth		Yes
Surgical removal of a supernumerary tooth	1 per tooth	The appropriate CDT extraction code and Universal/National Tooth Number must be reported on the claim.	Yes, if the particular extraction performed requires PA No, otherwise
Tooth reimplantation or stabilization of accidentally avulsed or displaced tooth or alveolus		Images of the area and a detailed explanation of the findings and treatment must be maintained in the patient's clinical record.	No
Alveoplasty, in conjunction with extraction, per quadrant Alveoplasty, not in conjunction with extraction, per quadrant	1 per quadrant	Alveoplasty is covered only in conjunction with the construction of a prosthodontic appliance.	No
Removal of benign odontogenic cyst or tumor, lesion diameter up to 1.25 cm Removal of benign odontogenic cyst or tumor, lesion diameter greater than 1.25 cm Removal of benign nonodontogenic cyst or tumor, lesion diameter up to 1.25 cm Removal of benign nonodontogenic cyst or tumor, lesion diameter greater than 1.25 cm		Images of the area and a detailed explanation of the findings and treatment must be maintained in the patient's clinical record.	No

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
Removal of lateral exostosis (maxilla or mandible) Removal of torus palatinus Removal of torus mandibularis		A diagnostic cast or photograph of the mouth with the area of surgery outlined must be maintained in the patient's clinical record.	No
Incision and drainage of abscess, intraoral soft tissue Incision and drainage of abscess, extraoral soft tissue		Images of the area, if applicable, and a detailed explanation of the findings and treatment must be maintained in the patient's clinical record.	No
Treatment of fracture in the alveolus, open reduction, with or without stabilization of teeth		Payment is made "by report" (on a case-by-case basis). Images of the area, if applicable, and a detailed explanation of the findings and treatment must be maintained in the patient's clinical record.	No
Frenulectomy (frenectomy/frenotomy)		A diagnostic cast or photograph of the mouth with the area of surgery outlined must be maintained in the patient's clinical record.	No
Excision of hyperplastic tissue, per arch		A diagnostic cast or photograph of the mouth with the area of surgery outlined must be maintained in the patient's clinical record.	No

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
ORTHODONTIC SERVICES Coverage of comprehensive orthodontic service is limited to treatment of existing or developing malocclusion, misalignment, or malposition of teeth that has, or may have, an adverse medical or psychosocial impact on the patient. Orthodontic service is considered to be medically necessary when its purpose is to restore or establish structure or function, to ameliorate or prevent disease or physical or psychosocial injury, or to promote oral health. Purely cosmetic orthodontic service is not covered. Prior authorization covers the entire course of comprehensive orthodontic treatment, up to a maximum of eight quarters, as long as the patient remains eligible for Medicaid services. If the patient becomes ineligible for Medicaid during the course of treatment, coverage and payment will continue through the end of the last quarter during which the patient is eligible. It is then the responsibility of the patient and the dentist to determine how payment is to be made for subsequent treatment. Payment for active treatment is payment in full. No additional payment can be sought from the patient or a third-party payer if the treatment requires more than eight quarters. A request for coverage by the department beyond 8 calendar quarters must be accompanied by extraordinary supporting documentation. After active treatment is completed, payment may be made for retention service, once per arch, under the original prior authorization. Payment will not be made for active treatment after retention service is begun. When prior authorization for comprehensive orthodontic service is denied, payment may still be made for images, cephalometric films, tracings, and diagnostic models. Full-mouth and panoramic images do not require prior authorization; separate claims may be submitted for these items.			
Comprehensive orthodontic service, active treatment	8 calendar quarters per course of treatment	Coverage is limited to patients younger than 21. Six items must be submitted with each PA request: (1) Lateral and frontal photographs of the patient with lips together. (2) Cephalometric film with lips together, including a tracing. (3) A complete series of intraoral images. (4) At least one diagnostic model. (5) A treatment plan, including the projected length and cost of treatment. (6) A completed evaluation and referral form, the ODM 03630 (01/2016).	Yes
Comprehensive orthodontic service, retention service, per arch	1 per arch	Coverage is limited to patients younger than 21. Retention service may be covered after active treatment has been completed.	Yes
Surgical access of an unerupted tooth	1 per tooth	Complete images must be submitted with each PA request.	Yes
Minor treatment to control harmful habits, removable appliance Minor treatment to control harmful habits, fixed appliance		Harmful habits include but are not limited to thumb- or finger-sucking, tongue-thrusting, and bruxism. Complete images, diagnostic models, or photographs of the mouth must be submitted with each PA request.	No, for removable appliances Yes, for fixed appliances

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
OTHER SERVICES			
Therapeutic drug injection		Payment is made "by report" (on a case-by-case basis).	No
Temporomandibular joint therapy Unspecified TMD therapy		Panoramic images, diagnostic casts, and a report of the clinical findings and symptoms must be submitted with each PA request. Payment includes follow-up adjustments for six months.	Yes
Maxillofacial prosthetics		A detailed treatment plan, full mouth images, and a hospital operative report (if applicable) must be submitted with each PA request.	Yes
Unspecified adjunctive procedure		This service entails unusual or specialized treatment required to safeguard the health and welfare of the patient. Detailed information on the difficulty and complications of the service, complete images of the mouth (if indicated) and an estimate of the usual fee charged for the service must be submitted with each PA request.	Yes

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
ANESTHESIA Payment for anesthesia services includes analgesic and anesthetic agents.			
Intravenous conscious sedation/analgesia General anesthesia		Anesthesia is generally covered for surgical or restorative procedures. Payment may also be made when a patient would be unable to undergo a nonsurgical procedure without sedation. Payment is made at a fixed amount (flat rate) per patient per date of service.	No

Appendix B to rule 5160-5-01

COVERED PROCEDURES

NC = No coverage PA = Prior authorization

HCPCS CODE	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT	PREVIOUS MAXIMUM PAYMENT
D0120	Periodic oral evaluation	07/01/2008	$17.08	$16.74
D0140	Limit oral eval problm focus	07/01/2008	$22.58	$22.13
D0150	Comprehensve oral evaluation	07/01/2008	$26.35	$25.82
D0180	Comp periodontal evaluation	01/01/2016	$26.35	NC
D0210	Intraor complete film series	07/01/2008	$60.00	$58.80
D0220	Intraoral periapical first	07/01/2008	$5.00	$4.90
D0230	Intraoral periapical ea add	07/01/2008	$5.00	$4.90
D0240	Intraoral occlusal film	07/01/2008	$12.00	$11.76
D0250	Extraoral first film	07/01/2008	$13.46	$13.19
D0270	Dental bitewing single image	07/01/2008	$5.00	$4.90
D0272	Dental bitewings two images	07/01/2008	$10.00	$9.80
D0273	Bitewings - three images	01/01/2007	$14.70	N/A
D0274	Bitewings four images	07/01/2008	$20.00	$19.60
D0321	Other tmj images by report	07/01/2008	$51.77	$50.73
D0330	Panoramic image	07/01/2008	$46.32	$45.39
D0340	Cephalometric image	07/01/2008	$60.00	$58.80
D0350	Oral/facial photo images	07/01/2008	$12.31	$12.06
D0470	Diagnostic casts	07/01/2008	$22.02	$21.58
D1110	Dental prophylaxis adult	07/01/2008	$34.13	$33.45
D1120	Dental prophylaxis child	07/01/2008	$20.00	$19.60
D1206	Topical fluoride varnish	01/01/2016	$15.00	NC
D1208	Topical app of fluoride	01/01/2013	$15.00	N/A
D1351	Dental sealant per tooth	07/01/2008	$22.00	$21.56
D1510	Space maintainer fxd unilat	07/01/2008	$113.71	$111.44
D1515	Fixed bilat space maintainer	07/01/2008	$163.28	$160.01
D1520	Remove unilat space maintain	07/01/2008	$125.08	$122.58
D1525	Remove bilat space maintain	07/01/2008	$133.79	$131.11
D2140	Amalgam one surface permanen	07/01/2008	$40.00	$39.20
D2150	Amalgam two surfaces permane	07/01/2008	$54.00	$52.92
D2160	Amalgam three surfaces perma	07/01/2008	$65.00	$63.70
D2161	Amalgam 4 or > surfaces perm	07/01/2008	$76.54	$75.01
D2330	Resin one surface-anterior	07/01/2008	$51.21	$50.19
D2331	Resin two surfaces-anterior	07/01/2008	$63.49	$62.22
D2332	Resin three surfaces-anterio	07/01/2008	$76.62	$75.09
D2335	Resin 4/> surf or w incis an	07/01/2008	$94.95	$93.05
D2390	Ant resin-based cmpst crown	01/01/2016	$94.95	NC
D2391	Post 1 srfc resinbased cmpst	07/01/2008	$51.21	$50.19
D2392	Post 2 srfc resinbased cmpst	07/01/2008	$54.00	$52.92
D2393	Post 3 srfc resinbased cmpst	07/01/2008	$65.00	$63.70
D2394	Post >=4srfc resinbase cmpst	07/01/2008	$76.54	$75.01
D2740	Crown porcelain/ceramic subs	01/01/2016	$427.29	NC
D2751	Crown porcelain fused base m	01/01/2016	$427.29	NC
D2752	Crown porcelain w/ noble met	07/01/2008	$427.29	$418.74
D2930	Prefab stnlss steel crwn pri	07/01/2008	$101.92	$99.88
D2931	Prefab stnlss steel crown pe	07/01/2008	$116.51	$114.18
D2933	Prefab stainless steel crown	07/01/2008	$153.00	$149.94
D2934	Prefab steel crown primary	01/01/2016	$153.00	NC
D2951	Tooth pin retention	07/01/2008	$16.49	$16.16
D2952	Post and core cast + crown	07/01/2008	$136.32	$133.59
D2954	Prefab post/core + crown	01/01/2016	$136.32	NC
D3220	Therapeutic pulpotomy	07/01/2008	$63.74	$62.47
D3310	End thxpy, anterior tooth	07/01/2008	$247.63	$242.68
D3320	End thxpy, bicuspid tooth	07/01/2008	$298.10	$292.14
D3330	End thxpy, molar	07/01/2008	$379.02	$371.44
D3351	Apexification/recalc initial	07/01/2008	$60.00	$58.80
D3352	Apexification/recalc interim	07/01/2008	$40.00	$39.20

HCPCS CODE	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT	PREVIOUS MAXIMUM PAYMENT
D3353	Apexification/recalc final	07/01/2008	$40.00	$39.20
D3410	Apicoectomy - anterior	07/01/2008	$178.00	$174.44
D4210	Gingivectomy/plasty 4 or mor	07/01/2008	$197.20	$193.26
D4211	Gingivectomy/plasty 1 to 3	01/01/2016	$118.80	NC
D4341	Periodontal scaling, 4 or more teeth	01/01/2016	$95.99	NC
D4342	Periodontal scaling, 1-3 teeth	01/01/2016	$65.00	NC
D4910	Periodontal maint procedures	01/01/2016	$34.13	NC
D5110	Dentures complete maxillary	07/01/2008	$400.00	$372.40
D5120	Dentures complete mandible	07/01/2008	$400.00	$372.40
D5211	Dentures maxill part resin	07/01/2008	$205.00	$190.86
D5212	Dentures mand part resin	07/01/2008	$205.00	$190.86
D5213	Dentures maxill part metal	07/01/2008	$540.25	$502.97
D5214	Dentures mandibl part metal	07/01/2008	$540.25	$502.97
D5510	Dentur repr broken compl bas	01/01/2016	$70.00	$50.00
D5520	Replace denture teeth complt	01/01/2016	$70.00	$40.00
D5610	Dentures repair resin base	01/01/2016	$70.00	$50.00
D5620	Rep part denture cast frame	01/01/2016	$81.90	$78.00
D5630	Rep partial denture clasp	01/01/2016	$77.70	$40.00
D5640	Replace part denture teeth	01/01/2016	$70.00	$37.24
D5650	Add tooth to partial denture	07/01/2008	$40.00	$37.24
D5660	Add clasp to partial denture	07/01/2008	$74.00	$68.89
D5750	Denture reln cmplt max lab	07/01/2008	$175.51	$163.40
D5751	Denture reln cmplt mand lab	07/01/2008	$175.80	$163.67
D5760	Denture reln part maxil lab	07/01/2008	$140.00	$130.34
D5761	Denture reln part mand lab	07/01/2008	$140.00	$130.34
D5899	Removable prosthodontic proc	01/01/2016	$40.00	PA
D5913	Nasal prosthesis	05/09/1986	PA	N/A
D5915	Orbital prosthesis	05/09/1986	PA	N/A
D5916	Ocular prosthesis	05/09/1986	PA	N/A
D5931	Surgical obturator	05/09/1986	PA	N/A
D5932	Postsurgical obturator	05/09/1986	PA	N/A
D5934	Mandibular flange prosthesis	05/09/1986	PA	N/A
D5935	Mandibular denture prosth	05/09/1986	PA	N/A
D5955	Palatal lift prosthesis	05/09/1986	PA	N/A
D5999	Maxillofacial prosthesis	10/01/2003	PA	N/A
D7140	Extraction erupted tooth/exr	01/01/2016	$57.69	$52.45
D7220	Impact tooth remov soft tiss	07/01/2008	$102.00	$99.96
D7230	Impact tooth remov part bony	07/01/2008	$151.46	$148.43
D7240	Impact tooth remov comp bony	07/01/2008	$188.80	$185.02
D7241	Impact tooth rem bony w/comp	01/01/2016	$200.00	$196.00
D7250	Tooth root removal	01/01/2016	$66.00	PA
D7260	Oral Antrl fistula closure	01/01/2016	$245.00	PA
D7270	Tooth reimplantation	01/01/2016	$101.06	By report
D7280	Exposure impact tooth orthod	07/01/2008	$152.30	$149.25
D7285	Biopsy of oral tissue hard	07/01/2008	$150.00	$147.00
D7286	Biopsy of oral tissue soft	07/01/2008	$130.00	$127.40
D7310	Alveoplasty w/ extraction	07/01/2008	$99.06	$97.08
D7320	Alveoplasty w/o extraction	07/01/2008	$120.64	$118.23
D7450	Rem odontogen cyst to 1.25 cm	01/01/2016	$105.79	By report
D7451	Rem odontogen cyst > 1.25 cm	01/01/2016	$230.59	By report
D7460	Rem nonodonto cyst to 1.25 cm	01/01/2016	$145.00	By report
D7461	Rem nonodonto cyst > 1.25 cm	01/01/2016	$240.29	By report
D7471	Rem exostosis any site	01/01/2016	$127.00	PA
D7472	Removal of torus palatinus	01/01/2016	$127.00	NC
D7473	Remove torus mandibularis	01/01/2016	$127.00	NC
D7510	I&d absc intraoral soft tiss	01/01/2016	$76.00	By report
D7520	I&d abscess extraoral	01/01/2016	$86.00	By report
D7671	Alveolus open reduction	10/01/2003	By report	N/A
D7899	Tmj unspecified therapy	07/01/2008	$482.50	$472.85

HCPCS CODE	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT	PREVIOUS MAXIMUM PAYMENT
D7960	Frenulectomy/frenectomy	07/01/2008	$119.13	$116.75
D7970	Excision hyperplastic tissue	01/01/2016	$66.00	PA
D8080	Compre dental tx adolescent	07/01/2008	$624.00	$611.52
D8210	Orthodontic rem appliance tx	07/01/2008	$205.00	$200.90
D8220	Fixed appliance therapy habt	07/01/2008	$300.00	$294.00
D8670	Periodic orthodontic tx visit	07/01/2008	$261.94	$256.70
D8680	Orthodontic retention	07/01/2008	$205.00	$200.90
D9220	General anesthesia	01/01/2016	$120.65	$95.65
D9241	Intravenous sedation	01/01/2016	$70.00	NC
D9610	Dent therapeutic drug inject	05/09/1986	By report	N/A
D9999	Misc adjunctive procedure	07/01/1971	PA	N/A

Ohio Department of Medicaid

REFERRAL EVALUATION FOR COMPREHENSIVE ORTHODONTIC TREATMENT

Individual	**Provider**
Name	Name
Medicaid ID number	Medicaid provider number
Date of birth	NPI

Mark all symptoms and indications that you observe in this patient.

Dentofacial Abnormality

- ☐ Marked protrusion of upper jaw and teeth
- ☐ Underdevelopment of lower jaw and teeth, receding chin
- ☐ Excessive spacing of front teeth
- ☐ Protrusion of upper or lower teeth such that lips cannot be brought together without strain
- ☐ Marked protrusion of lower jaw and teeth
- ☐ Marked crookedness, crowding, irregularity, or overlapping of teeth
- ☐ Marked asymmetry of lower face or transverse deficiency
- ☐ Cleft of lip or palate
- ☐ Abnormality of dental development
- ☐ Condition that increases likelihood of injury to teeth
- ☐ Condition that complicates or exacerbates TMJ dysfunction or another medical problem
- ☐ Other (Explain on the reverse side of the page.)

Tissue Damage Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ Marked recession of gums
- ☐ Loosening of permanent teeth
- ☐ Other (Explain on the reverse side of the page.)

Mastication Problem Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ Marked grimacing or motions of the oral-facial muscles when swallowing or difficulty in swallowing
- ☐ Socially unacceptable eating behavior caused by necessary compensation for anatomic facial deviations
- ☐ Pain when eating
- ☐ Other (Explain on the reverse side of the page.)

Respiration or Speech Problem Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ Postural abnormalities with associated breathing difficulties
- ☐ Malocclusion of jaws related to chronic mouth-breathing
- ☐ Lisping, articulation errors, or other speech impairment
- ☐ History of or recommendation for speech therapy
- ☐ Other (Explain on the reverse side of the page.)

Adverse Psychosocial Impact Related to Maloccluded, Misaligned, or Malposed Teeth

- ☐ (Explain on the reverse side of the page. Supporting statements may be attached from professionals, the patient, or the patient's family concerning the adverse impact on self-image, social interaction, or other psychological or social aspect of life.)

Signature	Date

TO BE RESCINDED

5160-5-01 **Dental program: general and co-payment provisions.**

(A) Eligible providers of dental services.

(1) All individuals currently licensed under state of Ohio law to practice dentistry are eligible to participate in the Ohio medicaid program as a dental provider upon execution of the "Medicaid Provider Agreement" according to rule 5101:3-1-17.2 of the Administrative Code.

(2) A professional dental group (group dental practice) is also considered eligible as a group dental practice if organized in accordance with rule 5101:3-1-17 of the Administrative Code, for the sole purpose of providing professional dental services.

(3) Dentists practicing and serving Ohio medicaid consumers outside of Ohio must be licensed by the dental examining board in their own state and must complete the "Medicaid Provider Agreement."

(4) Other eligible providers of dental services include, but are not limited to, the following medicaid providers if the providers employ or have under contractual arrangement individuals licensed to practice dentistry:

(a) Fee-for-service ambulatory health care clinics as defined in Chapter 5101:3-13 of the Administrative Code.

(b) Outpatient health facilities as defined in Chapter 5101:3-29 of the Administrative Code.

(c) Federally qualified health centers as defined in Chapter 5101:3-28 of the Administrative Code.

(B) General anesthesia.

(1) General anesthesia is reimbursable only when performed by a dentist who has an "Ohio state dental board permit."

(2) Dentists practicing and serving Ohio medicaid consumers outside the state of Ohio must meet the requirements of the dental examining board in their own

state for administering general anesthesia.

(C) Drugs.

(1) Drugs are provided under the medicaid program only upon written prescription of a physician, physician assistant, advanced practice nurse, or dentist.

(2) Providers are required to print or stamp their ten digit national provider identifier (NPI) number on the prescription blank or give their provider numbers to the pharmacist on prescriptions telephoned directly to the pharmacy.

(D) Co-payments (except for medicaid consumers enrolled in the medicaid managed health care program). For dates of service on or after January 1, 2006, the department has adopted a medicaid co-payment of three dollars per date of service per provider in accordance with rules 5101:3-1-09 and 5101:3-1-60 of the Administrative Code. Services provided to a consumer on the same date of service by the same provider are subject only to one co-payment.

(E) Unless otherwise specified, reimbursement for covered dental services provided by eligible providers to eligible consumers is contained in appendix DD of rule 5101:3-1-60 of the Administrative Code.

(F) Reimbursement for some services covered under the medicaid program is available only upon obtaining prior authorization from the Ohio department of job and family services (ODJFS) as specified in accordance with rule 5101:3-1-31 of the Administrative Code. Dental services which require prior authorization are identified in Chapter 5101:3-5 of the Administrative Code. A completed prior authorization request for such dental services is required for reimbursement consideration.

(1) All prior authorization requests must be submitted through the ODJFS web portal. Paper prior authorization requests will be returned to the provider unprocessed.

(2) Documentation necessary to complete the prior authorization request that cannot be uploaded and submitted through the ODJFS web portal, such as x-rays and dental molds, must be submitted separately.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5162.20, 5164.02
Rule Amplifies:	5162.03, 5162.20, 5164.02, 5164.70
Prior Effective Dates:	04/07/1977, 09/02/1985, 02/01/1988, 11/15/1993, 12/29/1995 (Emer), 03/21/1996, 01/01/2000, 10/01/2003, 01/01/2006, 07/01/2008, 08/02/2011

TO BE RESCINDED

5160-5-02 **Dental program: covered diagnostic services and limitations.**

The following dental examination codes may be billed for any place of service in accordance with the coverage and limitations set forth in Chapter 5101:3-5 of the Administrative Code.

(A) Clinical oral examination.

(1) Comprehensive oral evaluation.

(a) The comprehensive oral evaluation is typically used by a general dentist and/or a specialist when evaluating a consumer comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

A comprehensive oral evaluation would include the evaluation and recording of the consumer's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

(b) The comprehensive oral evaluation shall be limited to one per provider-consumer relationship.

(c) The comprehensive oral evaluation shall not occur in combination with the periodic oral evaluation.

(2) Periodic oral evaluation.

(a) This includes an evaluation performed on a consumer of record to determine any changes in the consumer's dental and medical health status since a previous comprehensive or periodic evaluation. This includes periodontal screening and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

(b) Effective for dates of service on or after January 1, 2006, the periodic oral evaluation shall not occur more frequently than once every one hundred eighty days for consumers twenty-years of age and younger. Those exams occurring more frequently shall not be reimbursed by the department.

(c) Effective for dates of service from January 1, 2006 through June 30, 2008, the periodic oral evaluation shall not occur more frequently than once every three hundred sixty-five days for consumers twenty-one years of age and older. Effective for dates of service from July 1, 2008 through December 31, 2009, the periodic oral examination shall not occur more frequently than once every one hundred eighty days irrespective of the consumer's age. Those exams occurring more frequently shall not be reimbursed by the department.

(d) Effective for dates of service on or after January 1, 2010, the periodic oral evaluation shall not occur more frequently than once every three hundred sixty-five days for consumers twenty-one years of age and older.

(e) The periodic oral evaluation shall not occur in combination with the comprehensive oral evaluation and not before one hundred eighty days after the comprehensive oral evaluation.

(3) Limited oral evaluation - problem focused.

(a) An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired though additional diagnostic procedures.

(b) The limited oral evaluation - problem focused shall include any necessary palliative treatment.

(c) Evaluations solely for the purpose of adjusting dentures are noncovered except as specified in rule 5101:3-28-04 of the Administrative Code.

(d) The limited oral evaluation - problem focused may not be billed in conjunction with other dental procedures, with the exception of x-rays on the same date of service.

(B) Radiographs/diagnositc imaging (including interpretation). All radiographs, when

presented to the department for review, shall be of diagnostic quality, properly mounted, properly exposed, clearly focused, clearly readable and free from defect for the area of the mouth on which the radiograph was performed.

(1) Intraoral, complete series (including bitewings).

(a) A complete series of radiographs shall consist of a minimum of twelve or more films. This shall include all periapical, bitewing, and occlusal film necessary for the diagnosis.

(b) A complete series of radiographs is allowed only once every five years. If a complete set of radiographs is required more frequently, prior authorization must be obtained.

(c) Periapical films shall show complete visibility of the periodontal ligament, crown and root structure in its entirety.

(2) Intraoral periapical, first film.

(3) Each additional intraoral periapical film.

(4) Intraoral occlusal film.

(5) Extraoral - first film. The extraoral film shall be allowed as an adjunct to complex treatment.

(6) Bitewing - single film.

(7) Bitewing - two films.

(8) Bitewing - three films.

(9) Bitewing - complete series, minimum of four films.

(a) The complete bitewing series is only reimbursable in the presence of erupted permanent second molars. Bitewing radiographs, in combination with other radiographs or when made alone, are allowed at six-month intervals providing they do not exceed the limitations set forth in paragraph (B) of this rule.

(b) Bitewing radiographs are permitted as frequently as at six month intervals, however, they are recommended at intervals of six to twenty four months, consistent with consumer risk for oral disease.

(c) Bitewing films shall show complete visibility of clinical crowns with no overlapping and cannot be substituted for periapical films in instances where endodontic treatment is necessary.

(10) Panoramic film.

(a) The panoramic film is an extraoral radiograph on which the maxilla and mandible are depicted on a single film.

(b) All bitewing and periapical film needed to render the necessary radiographic diagnosis is included in the fee for panoramic radiographs.

(c) Panoramic radiographs shall be permitted for consumers six years of age and older. If the dentist feels that it is medically necessary for a consumer under six years old to receive a panoramic radiograph, prior authorization must be obtained.

(d) Panoramic radiographs shall not be repeated more frequently than once every five years. If such radiographs are required more frequently, prior authorization must be obtained.

(e) Panoramic radiographs shall not occur in combination with a complete series of radiographs. A minimum of five years must elapse between the provision of panoramic radiographs and a complete series of radiographs, unless prior authorization is obtained.

(f) Panoramic films shall show complete visibility of tooth crowns, roots, bony and soft tissues in both arches with little or no overlapping of tooth crowns.

(11) Cephalometric film with tracing. Prior authorization shall be required for cephalometric films and tracings.

(12) Diagnostic photographs in conjunction with orthodontic treatment. Prior authorization shall be required for diagnostic photographs.

(13) Temporomandibular joint films. Prior authorization shall be required for temporomandibular joint films including submission of consumer history and treatment plan. Temporomandibular joint films to include four to six films are covered only if required by the department. Effective for dates of service from January 1, 2006 through June 30, 2008, temporomandibular joint films were covered only for consumers twenty-years of age and younger.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5162.20, 5164.02, Section 309.30.75 of Am. Sub. H.B. 1 (128th G.A.)
Rule Amplifies:	5162.03, 5164.02, 5164.70, Section 309.30.75 of Am. Sub. H.B. 1 (128th G.A.)
Prior Effective Dates:	04/07/1977, 12/21/1977, 05/09/1986, 02/01/1988, 11/15/1993, 12/29/1995 (Emer), 03/21/1996, 01/01/2000, 10/01/2003, 01/01/2006, 12/29/2006 (Emer), 03/29/2007, 07/01/2008, 01/01/2010

TO BE RESCINDED

5160-5-03 **Dental program: covered tests and laboratory examinations and limitations.**

The following tests and laboratory examinations are covered under the dental care program subject to the specified limitations.

(A) Biopsy of oral tissue - hard (bone, tooth).

(B) Biopsy of oral tissue - soft (all others).

(C) For the medicaid program, "biopsy" is defined as the removal of tissue from the patient for microscopic examination for the purpose of diagnosis, estimation of prognosis, and treatment planning.

(D) Diagnostic casts.

(1) Prior authorization shall be required for diagnostic casts. The prior authorization request for the diagnostic cast may be submitted with the completed cast when the cast is submitted for prior authorization for the proposed treatment. Prior authorization for the cast and the proposed treatment may be requested on the same prior authorization form. Providers may submit diagnostic casts in digital format or as a physical cast.

(2) Diagnostic casts shall be approved by the department for the evaluation of requested treatments listed throughout this chapter which state that diagnostic casts are necessary.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/07/1977, 12/21/1977, 05/09/1986, 02/01/1988, 01/01/2000, 10/01/2003, 01/01/2006

TO BE RESCINDED

5160-5-05 **Dental program: covered restorative services and limitations.**

The following restorative services are covered under the dental care program subject to the specified limitations.

(A) Amalgam restorations (including polishing).

(1) Amalgam - one surface, primary or permanent.

(2) Amalgam - two surfaces, primary or permanent.

(3) Amalgam - three surfaces, primary or permanent.

(4) Amalgam - four or more surfaces, primary or permanent.

(5) Payment shall not be made for separate occlusal restorations, other than on maxillary molars. Reimbursement for occlusal surface restorations, other than on maxillary molars, includes one or more restorations on that surface.

(B) Pin retention-exclusive of amalgam restoration per tooth, in addition to restoration. A maximum of three pins per tooth restoration shall be allowed as a covered service.

(C) Bases and copalite or calcium hydroxide liners placed under a restoration will be considered part of the restoration and not reimbursable as separate procedures.

(D) Local anesthesia shall be included in the fee for all restorative services.

(E) Resin - based composite restorations - direct.

(1) Resin-based composite restorations - anterior.

(a) Resin-based composite - one surface, anterior.

(b) Resin-based composite - two surface, anterior.

(c) Resin-based composite - three surface, anterior.

(d) Resin-based composite - four or more surfaces or involving incisal angle (anterior).

(2) Resin-based composite restorations - posterior.

(a) Resin-based composite - one surface, posterior.

(b) Effective for dates of service on or after January 1, 2004, resin-based composite - two surfaces.

(c) Effective for dates of service on or after January 1, 2004, resin-based composite - three surfaces, posterior.

(d) Effective for dates of service on or after January 1, 2004, resin-based composite - four or more surfaces, posterior.

(3) Pin retention - per tooth, in addition to restoration (resin-based composite). A maximum of three pins per tooth shall be allowed as a covered service.

(4) Resin-based composite restorations shall be permitted for anterior teeth and class I or class V restorations on posterior teeth.

(5) Effective for dates of service on or after January 1, 2004, resin-based composite restorations shall be permitted for class II restorations on posterior teeth.

(6) The fee for resin-based composite restorations shall include any necessary acid etching.

(F) Maximum reimbursement for restorations shall be limited to no more than three restorations per tooth regardless of the number of surfaces restored.

(G) Single surface resin-based composite restorations shall involve repair to decay into the dentin.

(H) A tooth with decay on three surfaces that can be restored with separate restorations in accordance with accepted standards of dental practice may be billed and will be reimbursed as separate restorations.

(I) Preventive resin restorations are not covered services.

(J) Crowns.

(1) Effective for dates of service from January 1, 2006 through June 30, 2008, crowns, posts and related services were not covered dental services for consumers twenty-one years and older.

(2) Crown - porcelain fused to noble metal.

(a) Prior authorization is required for porcelain fused to noble metal crowns. A periapical radiograph of the involved tooth must be submitted with each request.

(b) The fee for crowns includes the temporary crown which is placed on the prepared tooth and worn while the permanent crown is being prepared.

(c) Porcelain with metal crowns shall be authorized only for permanent anterior teeth.

(3) Prefabricated stainless steel crown. Stainless steel crowns shall be allowed only for teeth where multisurface restorations are needed and amalgam restorations and other materials have a poor prognosis.

(a) Prefabricated stainless steel crown - primary tooth

(b) Prefabricated stainless steel crown - permanent tooth.

(4) Prefabricated stainless steel crown with resin window. Open face stainless steel crown with aesthetic resin facing or veneer.

(a) Prefabricated stainless steel crowns with resin window shall be covered for anterior teeth only.

(b) The fee for prefabricated stainless steel crowns with resin window includes any necessary composite restoration.

(5) Cast post and core in addition to crown.

(a) Prior authorization is required for crowns with a post and core. A periapical radiograph of the involved tooth must be submitted with each request.

(b) Crowns with a post and core shall be approved only for endodontically treated permanent anterior teeth without sufficient tooth structure to support a crown.

Effective:

Five Year Review (FYR) Dates:

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Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5162.20, 5164.02
Rule Amplifies:	5162.03, 5164.02, 5164.70
Prior Effective Dates:	04/07/1977, 12/21/1977, 05/09/1986, 02/01/1988, 11/15/1993, 12/29/1995 (Emer), 03/21/1996, 01/01/2000, 10/01/2003, 01/01/2006, 07/01/2008

TO BE RESCINDED

5160-5-06 **Dental program: covered endodontic services and limitations.**

The following endodontic services are covered under the dental care program subject to the specified limitations.

(A) Therapeutic pulpotomy and pulpal therapy.

(1) Therapeutic pulpotomy and pulpal therapy shall be covered only for consumers under the age of twenty-one.

(2) Theraputic pulpotomy and pulpal therapy as separate procedures shall not occur in combination with root canal therapy.

(3) The restoration for the completed pulpal therapy or pulpotomy shall be billed as a separate procedure.

(B) Endodonic therapy (complete root canal therapy).

(1) Anterior - tooth (excluding final restoration).

(2) Bicuspid - tooth (excluding final restoration).

(3) Molar - tooth (excluding final restoration).

(4) Endodontic therapy is covered only when the overall health of the dentition and periodontium is good except for the endodontically indicated tooth/teeth. Decay must be above the bone level. Radiographs, including periapical, must be clearly readable and show periapical radioluncency or widening of periodontal ligament and be accompanied with chronic pain (as evidenced by sensitivity to hot or cold, percussion or palpation) or presence of fistula associated with tooth or chronic infection. If pathology is not visible on radiograph, endodontic treatment must be evidenced by clinical documentation.

(5) Endodontic therapy is covered only for permanent teeth.

(6) All diagnostic tests, evaluations, radiographs, and postoperative treatment are included in the fee.

(C) Apicoectomy/periradicular services.

(1) Apicoectomy/periradicular services shall be a covered service on permanent teeth only.

(2) Prior authorization is required for apicoectomy/periradicular services. All available radiographs of the mouth, properly mounted and clearly readable, must be submitted with each request. A periapical view of the tooth and the periapical area involved must be included.

(D) Apexification/recalcification procedures.

(1) Apical closure.

(a) Apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)

(i) Apexification/recalcification includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs.

(ii) This procedure may include the first phase of endodontic (complete root canal) therapy.

(b) Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)

This procedure is for visits in which the intra-canal medication is replaced with new medication and necessary radiographs.

(c) Apexification/recalcification - final visit (includes completed endodontic therapy - apical closure/calcific repair of perforations, root resorption, etc.)

(i) This procedure includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs.

(ii) This procedure includes last phase of endodontic (complete root

canal) therapy.

(2) Apical closure does not include endodontic (root canal) therapy.

(3) Prior authorization is required for each apexification/recalcification procedure.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/07/1977, 12/21/1977, 05/09/1986, 11/15/1993, 01/01/2000, 10/01/2003, 01/01/2006, 07/01/2008, 12/31/2008 (Emer), 03/31/2009, 12/30/2010 (Emer), 03/30/2011

TO BE RESCINDED

5160-5-07 **Dental program: covered periodontic services and limitations.**

The following periodontic services are covered under the dental care program subject to the specified limitations.

(A) Effective for dates of service from January 1, 2006 through June 30, 2008, periododonitc services were not covered services for consumers twenty-one years of age and older.

(B) Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant. Prior authorization is required for gingivectomy and gingivoplasty services. Complete radiographs of the mouth and diagnostic casts must be submitted with each request.

(C) Gingivectomy or gingivoplasty surgery is not usually covered under the medicaid program. One exception to program coverage limitations is to correct severe hyperplasia or hypertrophic gingivitis associated with drug therapy or hormonal disturbances.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	01/02/2000, 10/01/2003, 01/01/2006, 07/01/2008, 12/31/2008 (Emer), 03/31/2009

TO BE RESCINDED

5160-5-08 **Dental program: covered removable prosthodontic services and limitations.**

The following removable prosthodontic services are covered under the dental care program subject to the specified limitations.

(A) Complete dentures (including routine post-delivery care).

(1) Complete denture - maxillary.

(2) Complete denture - mandibular.

(3) All dentures must be prior authorized. In cases where the recipient is not edentulous prior to requesting dentures, complete radiographs of the mouth, properly mounted and clearly readable, must be submitted with each denture request. Radiographs must be taken prior to extractions. Radiographs are not necessary for those individuals edentulous prior to requesting dentures.

(4) The diagnosis for dentures shall be based on the total condition of the mouth, ability to adjust to dentures, and the desire to wear dentures. Natural teeth that have healthy bone, are sound, and do not have to be extracted must not be removed.

(5) Complete extractions must be deferred until authorization to construct the denture has been given, except in absolute emergency situations.

(6) The dental care program shall not authorize immediate dentures except in very unusual circumstances which must be documented and approved by the department.

(7) A denture, complete, partial, or combination thereof, shall not be replaced or remade within eight years except for very unusual circumstances.

(8) The dentist shall be responsible for constructing a complete functional denture. The fee for dentures includes all necessary corrections and adjustments for a period of six months after seating the denture.

(9) A preformed denture with teeth already mounted (that is, teeth already set in

acrylic prior to initial impressions), forming a denture module, is not a covered service.

(10) A denture shall not be authorized when dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable because of psychological or physiological reasons.

(B) Partial dentures.

(1) Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).

(2) Mandibular partial denture - cast metal framework with resin denture bases (including any coventional clasps, rests and teeth).

(3) Maxillary partial denture - resin base (including conventional clasps, rests and teeth). This procedure includes acrylic resin base denture with resin or wrought wire clasps. This procedure is a covered service for patients age eighteen and younger.

(4) Mandibular partial denture-resin base (including any conventional clasps, rests and teeth). This procedure includes acrylic resin base denture with resin or wrought wire clasps. This procedure is a covered service for patients age eighteen and younger.

(5) All partial dentures must be prior-authorized. Complete radiographs of the mouth, properly mounted and clearly readable, must be submitted with each request.

(6) Partial dentures cannot be replaced, remade, or exchanged for complete dentures for a minimum period of eight years except for unusual situations when justification for the new dentures can be established.

(7) Partial dentures are authorized when several teeth are missing in the arch and the masticatory function is severely impaired or when anterior teeth are missing in the arch which will affect the appearance of the patient.

(8) The dentist shall be responsible for constructing a complete functional partial denture. The fee for a partial denture includes all necessary corrections and adjustments for a period of six months after seating the partial denture.

(C) Repairs to dentures.

(1) Repairs to complete dentures.

(a) Repair broken complete denture base.

(b) Replace missing or broken teeth - complete denture (each tooth).

(2) Repairs to partial dentures.

(a) Repair resin denture base.

(b) Repair cast framework.

(c) Repair or replace broken clasp.

(d) Replace broken teeth - per tooth.

(e) Add tooth to existing partial denture.

(f) Add clasp to existing partial denture.

(D) Denture reline procedures.

(1) Reline complete maxillary denture.

(2) Reline complete mandibular denture.

(3) Reline partial maxillary denture.

(4) Reline partial mandibular denture.

(5) The reline must consist of the readaptation of the denture to the present oral tissues using accepted dental practice standards and procedures. The denture must be processed and finished with materials chemically compatible with the existing denture base. Chairside self-curing materials are not allowed.

(6) A complete or partial denture reline shall not occur more frequently than once

every four years and not before four years after construction of the complete or partial denture except for unusual circumstances which must be documented.

(7) All complete and partial denture relining procedures include six months of post-delivery care.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5162.20, 5164.02
Rule Amplifies:	5162.03, 5164.02, 5164.70
Prior Effective Dates:	04/07/1977, 12/21/1977, 05/09/1986, 01/04/1988, 11/15/1993, 12/29/1995 (Emer), 03/21/1996, 01/01/2000, 10/01/2003, 01/0120/06, 07/01/2008

TO BE RESCINDED

5160-5-09 **Dental program: covered oral surgery services and limitations.**

The following oral surgery services are covered under the dental care program subject to the specified limitations.

(A) The decision to remove a tooth or teeth must be based on the tooth or teeth being too broken down to save, too poorly supported by alveolar bone to save, and/or the presence of some pathological condition which contraindicates saving. Extractions that render a consumer edentulous must be deferred until authorization to construct a denture has been given, except in absolute emergency situations.

(B) The extraction of an impacted tooth is authorized only when conditions arising from such an impaction warrant its removal. The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is symptomatic.

(C) Local anesthesia and routine postoperative care are included in the fee for extractions.

(D) Extractions (includes local anesthesia, suturing, if needed and routine postoperative care).

(1) Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

(2) Extraction, erupted tooth or exposed root (elevation and/or forceps removal) may be billed only once per tooth.

(E) Surgical extraction.

(1) Removal of impacted tooth - soft tissue. A "soft tissue impaction" is any tooth which requires an incision of overlying soft tissue and removal of the tooth without necessity of removing the bone. Partial eruption of a tooth with portions of the crown located at or above the occlusal plane does not disqualify the tooth as a soft tissue impaction if the position is such that soft tissue does in fact cover portions of the occlusal surface, for example, distoangular position. This procedure shall be permitted for third molars only without prior authorization. All other procedures shall require prior authorization.

(2) Removal of impacted tooth - partially bony. A "partially bony impaction" is one

where the crown of the tooth is partially covered by bone. This tooth may or may not be partially erupted. This type of impaction requires an incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth. Partial eruption of a tooth with portions of the crown located at or above the occlusal plane does not disqualify this tooth from being classified a partially bony impaction if bone does in fact cover the greatest convexity of the distal portion of the crown, for example, distoangular position within the ramus of the mandible. If not visible on radiograph, bony impaction must be evidenced from clinical documentation. A radiograph of the impaction must be maintained in the patient's clinical record.

(3) Removal of impacted tooth - completely bony. A "completely bony impaction" is one where the crown of the tooth is completely covered by bone or a substantial part of the tooth above the greatest convexity of the crown is covered by bone on both the mesial and distal sides as demonstrated radiographically. In the case of horizontally impacted lower third molars, to be classified as a completely bony impaction the central groove of the crown must not be located superior to the occlusal plane. This type impaction requires an incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth, if necessary for removal. Prior authorization is required for all completely bony impactions including a radiograph of the impaction.

(4) Removal of impacted tooth - completely bony with unusual surgical complications. Prior authorization is required for all completely bony impactions including a radiograph of the impaction.

(5) Surgical removal of a residual tooth roots (cutting procedure). Prior authorization is required for this procedure.

(6) Surgical removal of a supernumerary tooth. Prior authorization is required for the surgical removal of a supernumerary tooth. Surgical removal of supernumerary teeth must be billed on a paper claim form using local level program code Y7255 until a CDT code is assigned for this procedure.

(F) Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus. This procedure shall be authorized by report. Submission of radiographs of the area and a detailed explanation of the findings and treatment are required for authorization.

(G) Alveoplasty - surgical perparation of ridges for dentures.

(1) Alveoplasty is a covered service only when provided in conjunction with the

construction of a prosthodontic appliance.

(2) Alveoplasty in conjunction with extractions - per quadrant.

(3) Alveoplasty, not in conjunction with extractions - per quadrant.

(H) Surgical excision.

(1) Coverage of removal of cysts or tumors is on a by-report basis. Submission of radiographs of the area and detailed explanation of findings and treatment are required for authorization.

(2) Removal of benign odontogenic cyst or tumor- lesion diameter up to 1.25 cm.

(3) Removal of benign odontogenic cyst or tumor- lesion diameter greater than 1.25 cm.

(4) Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.

(5) Removal of benign nonodontogenic cyst or tumor- lesion diameter greater than 1.25 cm.

(6) Removal of lateral exostosis (maxilla or mandible).

(a) Prior authorization is required for all removal of lateral exostosis procedures.

(b) A study cast of the mouth with the area of surgery outlined must be submitted for prior authorization.

(I) Surgical incision.

(1) Incision and drainage of abscess - intraoral soft tissue.

(2) Incision and drainage of abscess - extraoral soft tissue.

(3) Coverage of incision and drainage of abscesses is on a by-report basis requiring submission of radiographs of the area and detailed explanation of findings and treatment.

(J) Treatment of fractures.

(1) The treatment of fractures should be billed to the department using codes from the "American Medical Association's Current Procedural Terminology (CPT)".

(2) Alveolus - open reduction, may include stabilization of teeth, may be billed as a CPT code or dental code.

(K) Other repair procedures.

(1) Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure. Prior authorization is required and must include submission of complete radiographs of the mouth and study casts of the arch with outline of indicated surgery.

(2) Excision of hyperplastic tissue - per arch. Prior authorization is required and must include submission of complete radiographs of the mouth and study casts of the arch with the outline of the indicated surgery.

(L) Oral surgery services shall be billed to the department using procedure codes from either the surgery section, CPT codes or dental codes. Regardless of the code used, all claims must be submitted to the department on the appropriate claim type.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02
Prior Effective Dates:	04/07/1977, 12/21/1977, 05/09/1986, 01/04/1988, 11/15/1993, 01/01/2000, 10/01/2003, 01/01/2006, 07/01/2008, 12/30/2010 (Emer), 03/30/2011

TO BE RESCINDED

5160-5-10 **Dental program: covered orthodontic services and limitations.**

The following orthodontic services are covered under the dental care program subject to the specified limitations.

(A) Surgical access of an unerupted tooth. Coverage is limited to situations whereby an orthodontic attachment is placed on the crown to facilitate eruption. Prior authorization is required. Complete radiographs must be submitted with each request.

(B) Minor treatments to control harmful habits.

(1) Fixed appliance therapy.

(2) Removable appliance therapy.

(3) Prior authorization is required on all tooth guidance appliances to control harmful habits including, but not limited to, thumb- and finger-sucking, tongue-thrusting, and bruxism. Complete radiographs and study models of the mouth must be submitted with each request.

(C) Comprehensive orthodontics.

(1) Coverage of comprehensive orthodontics is limited to the most severe handicapping orthodontic conditions. Coverage is further limited to consumers under age twenty-one. Only one course of orthodontic treatment per consumer, per lifetime is covered.

(2) Prior authorization is required for all comprehensive orthodontic treatment. Effective December 7, 2010, all prior authorization requests must be submitted through the Ohio department of job and family services (ODJFS) web portal. Paper prior authorization requests will be returned to the provider unprocessed.

Documentation necessary to complete the prior authorization request that cannot be uploaded and submitted through the ODJFS web portal, such as x-rays and dental molds, must be submitted separately.

The following must be included with the prior authorization request:

(a) A completed prior authorization request.

(b) Lateral and frontal photographs of consumer with lips together.

(c) Cephalometric film with lips together, including a tracing.

(d) A complete series of radiographs or a panoramic radiograph.

(e) Diagnostic models.

(f) Treatment plan, including projected length and cost of treatment.

(g) A completed referral evaluation criteria form (JFS 03630/appendix to this rule). A consumer must demonstrate a minimum of five symptoms, with at least two of the symptoms appearing under dentofacial abnormality before the provider submits a request for consideration.

(3) Upon evaluation of all the documentation which includes study models, cephalometric film and tracing, radiographs, photographs, and the referral evaluation criteria form, the department will determine if the condition will be considered a severely handicapping orthodontic condition and covered by medicaid. If the case is denied, the prior authorization will be returned to the provider indicating that the orthodontic treatment will not be reimbursed by Ohio medicaid. However, an authorization will be issued for the payment of the photographs, cephalometric radiograph and tracing, and the diagnostic models. Full mouth radiographs and panoramic films do not require prior authorization and can be billed separately on a dental invoice by the dentist who provided the radiographs.

(4) The original prior authorization will cover the entire course of treatment as long as the consumer remains eligible for medicaid services. For those cases approved for treatment, the department will issue a prior authorization that approves payment for the records and the first quarter of treatment. Payment for subsequent quarters of orthodontic treatment will be made at the beginning of each quarter of active treatment through a maximum of eight quarters. Also, payment will be made for retention services after the active treatment is completed. The dentist, using the original prior authorization number, should bill the department every ninety days at the beginning of the quarter to receive payment for that quarter. At the end of the active treatment, the department can be billed one time per arch for retention service. Payment will not be made for active treatment after retention is begun.

(5) If the consumer becomes ineligible during the time that comprehensive orthodontic treatment is being rendered, the quarter payment will permit coverage to continue through the end of the authorized quarter of treatment. For example, if the prior authorized treatment quarter begins February first, and the consumer becomes ineligible as of March first, treatment is to continue through the remainder of the quarter for which payment has been made, (February first - April thirtieth). It will be the responsibility of the consumer and the dentist to determine a payment mechanism for subsequent quarters of treatment provided when the consumer is ineligible for medicaid.

(6) Payment for active treatment will be made for a maximum of eight quarters. In some cases more than eight quarters may be necessary to complete treatment. However, the fee associated with eight quarters of treatment is the maximum amount reimbursable and is considered payment-in-full. No additional reimbursement can be sought from the department, consumer, or other source if the treatment requires additional quarters.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02, 5164.70
Prior Effective Dates:	04/07/1977, 09/02/1985, 05/09/1986, 02/01/1988, 11/15/1993, 08/01/1995, 12/29/1995 (Emer), 03/21/1996, 10/01/2003, 01/01/2006, 07/01/2008, 08/02/2011

Ohio Department of Medicaid

REFERRAL EVALUATION CRITERIA FOR COMPREHENSIVE ORTHODONTIC TREATMENT

Client Name			Billing Number
Provider Name	NPI	Provider Number	Date

Check the symptoms and signs of physical conditions that you observe in this patient.

Dentofacial abnormality

- ☐ Marked protruding upper jaw and teeth
- ☐ Underdeveloped lower jaw and teeth, receding chin
- ☐ Excessively spaced front teeth
- ☐ Upper or lower teeth protruding so much that lips cannot be brought together without strain
- ☐ Marked protruding lower jaw and teeth
- ☐ Extremely "crooked" front teeth
- ☐ Marked asymmetry of lower face or transverse deficiencies
- ☐ Clefts of lip or face
- ☐ Abnormalities of dental development
- ☐ Other (explain on other side of page)

Tissue Damage Related to Malocclusion

- ☐ Marked recession of gums
- ☐ Loosened permanent teeth
- ☐ Other (explain on other side of page)

Mastication Related to Malocclusion

- ☐ Extreme grimacing or excessive motions of the oral-facial muscles during swallowing
- ☐ Socially unacceptable behavior during eating because of necessary compensation for anatomic facial deviations
- ☐ Pain in jaw joints when eating
- ☐ Other (explain on other side of page)

Respiration and Speech Related to Malocclusion

- ☐ Postural abnormalities with breathing difficulties
- ☐ Malocclusion of jaws related to chronic mouth breathing
- ☐ Lisping or other speech articulation errors in children 9 years old or older
- ☐ History of, or recommendation for speech therapy
- ☐ Other (explain on other side of page)

Dentist Signature	Date

TO BE RESCINDED

5160-5-11 **Dental program: other covered services and limitations.**

The following services are covered under the dental care program subject to the specified limitations.

(A) Anesthesia for dental procedures.

(1) "General anesthesia" is defined as a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, inability to independently maintain an airway, inability to respond purposefully to physical stimulation or verbal command with resultant amnesia related to the surgical procedure.

(2) General anesthesia shall be reimbursed at a flat rate per consumer per date of service. A twenty-five dollar in-office incentive payment shall be added to the reimbursement for general anesthesia provided in an office setting.

(3) The administration of general anesthesia will be covered for surgical and restorative procedures when performed by an eligible provider as defined in rule 5101:3-5-01 of the Administrative Code. The cost of analgesic and local anesthetic agents is included in the fees associated with dental services reimbursed by the medicaid program.

(B) Dental services performed in long-term care facilities or private homes.

(1) Dental services rendered to consumers in long-term care facilities or private homes are covered in accordance with the coverage and limitations set forth in Chapter 5101:3-5 of the Administrative Code.

(2) An updated medical and dental history, diagnosis, prognosis, and treatment plan must be maintained in the provider's office. For consumers residing in long-term care facilities, a copy of this record must also be maintained in the facility.

(3) A record of the request for treatment, signed by the consumer, family member, responsible guardian, or attending physician, must be maintained in the consumer's permanent record at the long-term care facility and the provider's office.

(4) When requesting services that require prior authorization (PA), a copy of the request for treatment must be submitted with the PA request along with any study casts or radiographs that may be required. Additionally, when the PA request is for dentures or partials, a copy of the most recent nursing care plan must be submitted to the department with the request.

(C) Inpatient hospital services.

All elective inpatient hospital admissions require preadmission certification in accordance with rule 5101:3-2-40 of the Administrative Code.

(D) Therapeutic drug injection, by report. This procedure shall be authorized by report.

(E) Temporomandibular therapy.

(1) Effective for dates of service from January 1, 2006 through June 30, 2008, temporomandibular therapy services were not covered services for consumers twenty-one years of age and older.

(2) All treatment for temporomandibular joint therapy requires prior authorization.

(3) Panaromic radiographs, diagnostic casts, and a report of the clinical findings and symptoms must be submitted with each request for prior authorization.

(4) The fee allowed for the temporomandibular therapy includes six months of adjustments.

(F) Maxillofacial prosthetics. Prior authorization is required and must include a detailed treatment plan, full mouth radiographs, and hospital operative report, if applicable.

(G) Miscellaneous services. Unspecified adjunctive procedure, by report.

(1) Unusual and/or specialized treatment required to safeguard the health and welfare of the consumer.

(2) Prior authorization is required and must include detailed information on the difficulty and complications of the service and complete radiographs of the mouth, if indicated. An estimation of the usual fee charged for the service must also be submitted with the prior authorization request.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5162.20, 5164.02
Rule Amplifies:	5162.03, 5164.02, 5164.70
Prior Effective Dates:	01/02/2002, 10/01/2003, 01/01/2006, 07/01/2008

TO BE RESCINDED

5160-5-04 **Dental program: covered preventive services and limitations.**

The following preventive services are covered under the dental care program subject to the specified limitations.

(A) Prophylaxis.

(1) Dental prophylaxis, adult.

(a) This shall include the necessary scaling and/or polishing procedures of the teeth to remove coronal plaque, calculus and stains of transitional or permanent dentition for consumers ages fourteen and older.

(b) Effective for dates of service on or after January 1, 2006, the dental prophylaxis shall not occur more frequently than once every one hundred eighty days for consumers twenty-years of age and younger. Those prophylaxes occurring more frequently than once every one hundred eighty days shall not be reimbursed by the department.

(c) Effective for dates of service from January 1, 2006 through June 30, 2008, the dental prophylaxis shall not occur more frequently than once every three hundred sixty-five days for consumers twenty-one years of age and older. Effective for dates of service from July 1, 2008 through December 31, 2009, the dental prophylaxis shall not occur more frequently than once every one hundred eighty days irrespective of the consumer's age. Those prophylaxes occurring more frequently than once every one hundred eighty days shall not be reimbursed by the department.

(d) Effective for dates of service on or after January 1, 2010, the dental prophylaxis shall not occur more frequently than once every three hundred sixty-five days for consumers twenty-one years of age and older.

(2) Dental prophylaxis, child.

(a) This shall include the necessary scaling and/or polishing procedures to remove coronal plaque, calculus and and stains of primary or transitional dentition for consumers only through age thirteen.

(b) The dental prophylaxis shall not occur more frequently than once every one hundred eighty days. Those prophylaxes occurring more frequently than once every one hundred eighty days shall not be reimbursed by the department.

(B) Topical application of fluoride.

(1) Topical fluoride treatments (includes sodium, stannous and acid phosphate fluoride foam, gel, varnish and in-office rinse) shall be allowed for consumers under the age of twenty-one.

(2) Treatment that incorporates fluoride with the polishing compound shall be considered part of the prophylaxis procedure and not a separate topical fluoride treatment.

(3) Topical application of fluoride to the prepared portion of a tooth prior to restoration, the use of self or home fluoride application procedures, and application of sodium fluoride as a desensitizing agent are not covered treatments.

(4) The topical application of fluoride is limited to one application per one hundred eighty days.

(C) Sealant - per tooth. Pit and fissure sealants shall be permitted on previously unrestored occlusal areas of permanent molars subject to the following limitations:

(1) Sealants shall be allowed on permanent first molars for consumers under age eighteen.

(2) Sealants shall be allowed on permanent second molars for consumers under age eighteen.

(D) Space maintenance (passive appliances).

(1) Effective for dates of service from January 1, 2006 through June 30, 2008, space maintenance (passive appliances) were not covered services for consumers twenty-one years of age and older.

(2) Space maintainer - fixed - unilateral.

(3) Space maintainer - fixed - bilateral.

(4) Space maintainer - removable - unilateral.

(5) Space maintainer - removable bilateral.

(6) The preservation of arch length should be the main consideration in the evaluation of a consumer for a space maintainer. Space maintainers are permitted after the loss of a young permanent tooth or the premature loss of a primary tooth when an indeterminant time exists before the eruption of the permanent tooth.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02, Section 309.30.75 of Am. Sub. H.B. 1 (128th G.A.)
Rule Amplifies:	5162.03, 5164.02, 5164.70, Section 309.30.75 of Am. Sub. H.B. 1 (128th G.A.)
Prior Effective Dates:	04/07/1977, 12/21/1977, 05/09/1986, 02/01/1988, 11/15/1993, 01/01/2000, 10/01/2003, 01/01/2006, 07/01/2008, 12/31/2008 (Emer), .03/31/2009, 01/01/2010, 12/31/2012 (Emer), 03/28/2013