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:

Amend: Rule 5160-5-01 with appendices A and B and Form ODM 03630

Date: April 15, 2016

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- ☐ Rescinded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.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIOhio@governor.ohio.gov

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.

   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.

   This rule is being amended to correct a technical detail in language pertaining to the payment for covered dental services provided in rural Ohio counties. Payment will be made at the lesser of the submitted charge or one hundred five percent of the amount listed in Appendix B of the rule.

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.**

   This rule does 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. This rule sets forth Medicaid coverage and payment policies for dental services.

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

   The success of this rule 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

The current rule, which became effective January 1, 2016, took into account comments from all these stakeholder groups. It states that providers of covered dental services in rural counties can be paid the lesser of 105% of the submitted charges or 105% of the amount listed in Appendix B of the rule. However, federal Medicaid provisions limit payment to provider's customary charges. Accordingly, the rule is being amended to provide that payment will be made at the submitted charge or one hundred five percent of the amount listed in Appendix B of the rule.

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

Key stakeholders were apprised of the reason for the most recent amendment of the rule. The Ohio Dental Association and Ohio Department of Health discussed options that providers potentially impacted by this change could follow to receive the 105% rural dental fee differential as allowed by this rule. Those options were considered in the draft regulation being proposed by ODM.

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?

This rule involves 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 this rule 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 this rule affect dentists and other eligible Medicaid providers of dental services, such as fee-for-service clinics in rural Ohio counties.

b. This rule imposes no license fees or fines. The rule indicates that no eligible provider may receive payment without a valid Medicaid provider agreement. The rule specifies 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 this rule 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.

This rule 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?

This rule 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.

*** DRAFT - NOT YET FILED ***

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

*** DRAFT - NOT YET FILED ***

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

*** DRAFT - NOT YET FILED ***

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.

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 moderate conscious sedation/ analgesia Deep sedation/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	01/01/2016	$70.00	$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
D9223	Deep sedation/general anesthesia	01/01/2016	$120.65	NA
D9243	Intravenous conscious sedation/analgesia	01/01/2016	$70.00	NA
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