Ohio | Common Sense Initiative

Mike DeWine, Governor
Jon Husted, Lt. Governor

Carrie Kuruc, Director

Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid (ODM)

Rule Contact Name and Contact Information:

Tommi Potter, Rules Administrator, tommi.potter@medicaid.ohio.gov, 614-752-3877

Regulation/Package Title (a general description of the rules' substantive content):

Dental services

Rule Number(s): 5160-5-01

Date of Submission for CSI Review: 09/17/2019

Public Comment Period End Date: 09/24/2019

Rule Type/Number of Rules:

New/___rules

Amended/ 1 rules (FYR? Y)

No Change/____rules (FYR?___)

Rescinded/____rules (FYR?___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☐ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☐ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **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 one appendix that lays out coverage of dental services by category.

   A dated reference has been updated in the rule body.

   Changes incorporated into appendix A include the following:

   - Procedure code terminology is updated based on Code on Dental Procedures and Nomenclature (CDT) changes for 2020. The descriptors for covered space maintainers and several covered procedure codes for partial dentures have been revised.
   - Coverage is updated for the application of silver diamide fluoride (SDF) to "per tooth" with a limit of up to four teeth reimbursed per date of service and a lifetime limit of four applications per tooth.
   - Coverage is extended to include: more specific occlusal guard procedure codes at same maximum fees and limits as currently covered removable oral appliances and immediate complete dentures at the same maximum fee and limit as currently covered complete dentures. Relines of complete immediate dentures within the first six months of placement are included

in the adjustment period of the dentures and are not separately reimbursed.

- The limit for partial and complete denture relines is changed from every four years to every 3 years based on medical necessity.
- Payment for in-office dental general anesthesia services and in-office intravenous sedation services is increased. Payment per date of service is limited to one unit of the first 15 minutes and up to four units of subsequent 15 minute increments.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

   Section 5164.02 of the Ohio Revised Code.

4. **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.

   Dental services are an optional service under 42 U.S.C. 1396d(a)(10) that the Ohio Department of Medicaid has decided to cover under its state plan which is approved by the Centers for Medicare and Medicaid Services (CMS). The regulation is necessary to operationalize the federal provision of this service.

5. **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.

6. **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)?**

   The public purpose for this regulation is to assure that Medicaid-eligible individuals can receive Medicaid covered dental services provided by Medicaid-eligible dental providers authorized to provide such services at the fees or pricing as determined by ODM. The documentation requirements spelled out in this rule serves as 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.

7. **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 Medicaid-eligible individuals are able to receive covered dental services from Medicaid-eligible dental providers and operational updates to the Medicaid Information Technology System (MITS) result in the correct payment of claims for these services.

8. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

No.

Development of the Regulation

9. **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 rule:

- Ohio Dental Association (ODA)
  - ODA Council on Access to Care and Public Services
  - ODA Medicaid workgroup
- Ohio Department of Health's Oral Health and Maternal and Child Health Services staff
- Ohio State and Case Western Reserve Colleges of Dentistry leadership and clinic administrators Ohio State Dental Board
- Ohio State Dental Board
- Lobbyists representing dentists and other oral health stakeholders
- Children's Oral Health Action Team (COHAT)
- Ohio Association of Community Health Centers (OACHC)
- Ohio Department of Medicaid's Dental Director
- Medicaid managed care plans
- Practicing Medicaid dentists including several who serve as dental technical advisors (MTAs) to Ohio Medicaid Managed Care plans.

10. **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 continue the dental program review and development. The primary suggestions were: proposals for increased Medicaid fees, coverage of blood glucose testing, revised coverage of silver diamine fluoride to match new procedure code description, coverage of occlusal guards under more specific procedure codes, coverage of additional types of complete dentures and changes to reimbursement of general anesthesia and sedation services. Suggestions identified by specific stakeholders are often discussed with other stakeholders for additional viewpoints and feedback.

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 which fosters on-going input. 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 2, 2018, April 26, 2019 and August 9, 2019. Discussion topics included Medicaid dental services coverage and limitations, program requirements, and program policy. Because of these meetings, rule language was drafted to incorporate coverage of silver diamine fluoride per tooth with a maximum of four teeth being reimbursed per visit and coverage was extended to equivalent procedure codes at the same maximum payment amounts as existing covered codes.

Six of the eight members of the ODA Medicaid workgroup have participated in one of more other stakeholder groups to discuss potential dental program changes Individual consensus was reached regarding ADA coding changes for 2020, coverage of equivalent procedure codes, coverage of silver diamine fluoride, coverage of immediate complete dentures and increased reimbursement of in-office dental general anesthesia services and in-office intravenous sedation services.

Dentists from a multi-location dental practice requested that ODM cover immediate complete dentures on March 20, 2019 and in subsequent phone calls and e-mails They explained that during the wait (3-10 weeks) for traditional dentures to be fabricated and returned from the laboratory, patients become used to eating without teeth and their jaw and bite adjust to being edentulous making it difficult for them to use the new dentures. They explained that many patients do not come back to pick-up their traditional dentures or do not use their new dentures as a result. They said with immediate dentures the patient receives dentures while in the office and the prosthodontic serves to reduce swelling and acts as a “bandage” to assist in healing. Immediate dentures require more frequent relining which would be an additional cost to ODM.

Various dentists questioned the suggested reason for covering immediate dentures. Most were supportive of the idea but emphasized covering immediate dentures will be more expensive to ODM in the first 6 months for a reline and possibly, longer term for additional relines. The durability of immediate dentures was discussed. If immediate dentures are covered, it was suggested that ODM would likely have to change its policy to allow more frequent denture relines.

A manufacturer of prefabricated dentures with preformed teeth talked with ODM staff regarding coverage of their type of complete dentures on June 20, 2019. He asked that ODM allow coverage of this type of denture. Concern was expressed regarding the fit and durability of these “off the shelf” dentures.

ODM staff met with representatives of the two Ohio dental colleges between September of 2018 and May of 2019. Discussions generally focused on the short supply of dentists in Ohio, training efforts to coordinate oral health and primary medical health services and Medicaid funding (fees) for their clinics. Clarification of program coding and coverage of certain services were a major point of discussion.

Both colleges support changing coverage of silver diamine fluoride to per tooth with limits on the maximum reimbursement per date of service.

ODM meet with staff of the Ohio State Dental board on January 14, 2019 to discuss several Board initiatives and which dental professionals could render certain Medicaid covered services within their licensure and scope of practice. The application of silver diamide fluoride was one of the covered services discussed.

ODM has had direct and indirect contact with other state agencies and various associations and oral health advocacy groups, such as OHO and OACHC regarding access to dental services for Medicaid consumers, program fees and program funding. FQHC based dentists asked for coverage of blood glucose testing in the dental program due to their wellness initiatives and co-location with medical providers. Private practice dentists told ODM they wrestle with the liability of referring patients with abnormal results to a physician and assuring patients follow-up with a physician.

Other advocates, providers and lobbyists met with ODM staff members in 2018 and 2019, primarily about coverage of equivalent services to assist in correct coding initiatives, program fees and coverage of immediate dentures.

On September 24, 2018, February 7, 2019 and May 16, 2019, administrative staff and ODM's dental director and managed care plan dental directors met to discuss program operation and possible program changes. The dental director of one MMCP dental benefit administrator (DBA), raised the question of differentiating coverage of occlusal guards under new CDT procedure codes, D9994 – D9996, rather than relying on less specific oral appliance procedure codes. ODM has covered removable occlusal guards and other appliances under D8210 "removable appliance therapy" with no age restriction. The recommendation was accepted to cover the more specific occlusal guard procedure codes, D9944 through D9946, at the same fee and coverage as D8210.

Another dental director suggested ODM change how it reimburses general anesthesia and sedation services stating that current reimbursement of a "loaded unit" was causing confusion for some dentists. Discussion of coding, billing, rule language and payment for these services was discussed. It was noted that managed care plans have the flexibly to reimburse services differently and, in some cases, plans are doing so for these services.

Requests for input and the proposed dental program changes were communicated to Ohio Medicaid managed care plans through ODM's managed care plan contract administrators and during regular administrative meetings with the plans.

Because of these meetings, ODM is proposing to adopt the ADA 2020 code set and rule language was drafted to incorporate coverage of: silver diamine fluoride, per tooth with reimbursement limits, occlusal guards under new CDT procedure codes, D9994 – D9996, and immediate complete dentures to include any relines within six months. Coverage of all denture relines was changed from four years to three years based on medical necessity.

Program coverage and payment of silver diamide fluoride was clarified as the Ohio State Dental board issued regulation regarding which dental professionals could render this service within their licensure and scope of practice.

Payment for in-office dental general anesthesia services and in-office intravenous sedation services is being increased . Payment per date of service is limited to one unit of the first 15 minutes and up to four units of subsequent 15 minute increments.

Coverage of blood glucose testing in the dental program was deferred pending further consideration of coverage and how to best utilize the information it provides in the dental program is needed. Blood glucose testing is a covered service in an FQHC as a medical encounter.

Coverage of dentures is with preformed teeth is deferred until evidence-based research is available.

The aim of this rule update is to provide cost-effective alternatives, to recognize changes in the practice of dentistry and to increase program participation with minimal additional cost to the state.

11. **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.

12. **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?**

ODM has determined that an OAC rule stating the coverage of and payment for dental procedures is the most effective way to administer this program.

13. **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 was determined to be beyond the scope of this program rule.

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

ODM reviewed existing state laws to ensure there was not duplication or conflict with these regulations.

15. **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) claims payment system 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.

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

Adverse Impact to Business

16. **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; and**
    b. **Identify the nature of all adverse impact (e.g., 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 who are enrolled as Medicaid providers and other eligible Medicaid providers of dental services who may employ or contract with dentists who are enrolled as Medicaid providers, such as fee-for-service clinics to render services to Medicaid covered individuals.

b. This rule imposes no license fees or fines. Practitioners must maintain and, as appropriate, submit 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. It is not expected that the proposed revisions to the rule will create any new adverse impact

The rule will not increase expenses or decrease revenue.

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 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).

17. 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 serves as 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

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

This rule outlines actions all dental providers must take to receive Medicaid payment. They do not set forth requirements for engaging in business, and no exception is made based on the size of an entity.

19. 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 imposes no sanctions on providers.

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

Providers may utilize ODM resources to understand dental program coverage and limitations and current Medicaid claim-submission procedures.

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

ODM's Bureau of Provider Services also renders technical assistance to providers through its provider hotline, (800) 686-1516.

Policy questions may be directed via e-mail to the Non-Institutional Policy 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;

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

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

(B) Definitions.

(1) "Metropolitan statistical area (MSA)" has the same meaning as in 40 C.F.R. 58.1 (~~July 1, 2017~~ October 1, 2019).

(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 DD to rule 5160-1-60 of the Administrative Code.

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

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

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 either a comprehensive oral evaluation, periodic oral evaluation or periodontal evaluation.	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
Tobacco counseling for control and prevention of oral disease	2 per 365 days	Coverage is limited to patients with a history of tobacco use. This service must be provided in conjunction with another dental service. Documentation of tobacco use, extent of counseling session, and provision of cessation assistance or referral must be maintained in the clinical record.	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

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
Interim caries arresting medicament application	4 times per tooth per lifetime. ~~6 per lifetime~~	No payment is made in conjunction with a restoration or crown on the same tooth. Payment is limited to up to 4 teeth per date of service regardless of number of units billed or teeth treated. ~~. Payment is limited to a fixed amount (flat rate of one unit) per patient, per date of service regardless of number of units billed or teeth treated.~~	No
Space maintainer, fixed unilateral - per quadrant Space maintainer, fixed bilateral, maxillary Space maintainer, fixed bilateral, mandibular Space maintainer, removable unilateral - per quadrant Space maintainer, removable bilateral, maxillary Space maintainer, removable bilateral, mandibular		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 is permitted only for teeth on which multisurface restorations are needed and amalgam restorations and other materials have a poor prognosis. 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). A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces. On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface. On anterior teeth, the facial and lingual surfaces can be named twice, whether performed alone or in combination with restorations of another surface. If the incisal angle on an anterior tooth is involved, then only one four-surface restoration can be claimed for the tooth and no additional surfaces or restorations will be allowed.			
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 unless otherwise specified. 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 unless otherwise specified. Preventive restoration is not covered.	No
Pin retention, in addition to resin-based composite restoration	3 pins per tooth		No

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
Crown, porcelain fused to noble metal Crown, porcelain fused to predominately base metal Crown, porcelain/ceramic substrate		A fused porcelain or porcelain/ceramic substrate crown may be covered for permanent anterior teeth only. A periapical image of the involved tooth must be submitted with each PA request.	Yes
Crown, prefabricated porcelain/ceramic – primary tooth 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 prefabricated porcelain/ceramic – primary tooth is reimbursed at different maximum fees for primary anterior and posterior teeth. 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
Core buildup, including any pins when required	1 per tooth	Coverage is limited to permanent teeth. This service must be provided in preparation for or in conjunction with an adult crown procedure.	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 Immediate complete denture, maxillary Immediate 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 partial 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 retentive/clasping materials, ~~conventional clasps,~~ rests, and teeth), maxillary Partial denture, cast metal framework with resin base (including retentive/clasping materials, ~~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 broken base complete denture, mandibular Repair of broken base complete denture, maxillary Replacement of missing or broken teeth, complete denture (each tooth) Repair of resin partial base, mandibular Repair of resin partial base denture, maxillary Repair of cast partial framework, mandibular Repair of cast partial framework, maxillary Replacement of missing or broken teeth partial denture (each tooth) 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 3 years ~~1 per 4years~~ and no sooner than 3 years ~~4 years~~ after initial construction, except in unusual circumstances	All relining procedures include post-delivery care for six months. Relines of complete immediate dentures within the first six months of placement are included in the adjustment period of the denture and are not separately reimbursed.	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
Extraction, erupted tooth removal of bone and/or sectioning of tooth including elevation of flap if indicated	1 per tooth		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

SERVICE	QUANTITY/FREQUENCY LIMIT	OTHER CONDITION OR RESTRICTION	PRIOR AUTHORIZATION (PA) REQUIRED
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
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, closed reduction, with or without stabilization of teeth Treatment of fracture in the alveolus, open reduction, with or without stabilization of teeth		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
Placement of device to facilitate eruption of impacted 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, single administration Therapeutic drug injection, two or more administrations, different medications			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
Occlusal guard – hard appliance, full arch, Occlusal guard – soft appliance, full arch Occlusal guard – hard appliance, partial arch		Removable dental appliance to minimize effects of bruxism or other occlusal factors. Not to be used for any type of sleep apnea, snoring or TMD appliance.	No
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 for intravenous conscious sedation/analgesia services is limited to one unit of the first 15 minutes and up to four units of subsequent 15 minute increments per date of service. ~~Payment for intravenous conscious sedation/analgesia services is made at a fixed amount (flat rate) per patient, per date of service regardless of anesthesia time or procedure codes and units billed.~~ Payment for deep sedation/general anesthesia services is limited to one unit of the first 15 minutes and up to four units of subsequent 15 minute increments per date of service. ~~Payment for deep sedation/general anesthesia services is made at a fixed amount (flat rate of one unit) per patient, per date of service regardless of anesthesia time or procedure codes and units billed.~~	No