## Appendix to OAC Rule 5160-5-01 Dental Services

***Frequency limits may be exceeded with prior authorization on the basis of medical necessity.**

| SERVICE DESCRIPTION | 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, cancer evaluation 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. A treatment plan is formulated and discussed with the patient, as indicated, based on the clinical findings. 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 cancer evaluation and periodontal screening. Interpretation of information may require additional diagnostic procedures, which should be reported separately. | Patient younger than 21: 1 per 180 days<br><br>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.<br><br>Dental evaluations are covered 1 per 180 days for ~~pregnant women and~~ several special groups including, but not limited to, pregnant women, ~~such as~~ foster children and employed individuals with disabilities regardless of their age. | No |

AMENDED
Appendix
5160-5-01

| SERVICE DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| Limited oral evaluation, problem-focused – An evaluation limited to a specific oral health problem or complaint, it includes any necessary palliative treat- ment. Not to be used for a teledental encounter when the level of information available is not equivalent to that obtained in an in-office environment. 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.<br><br>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 – Procedure indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. | 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 |

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|---|---|---|---|
| **DIAGNOSTIC IMAGING, INCLUDING INTERPRETATION**<br>A diagnostic image may be submitted either as a tangible object or as a digital representation.<br>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.<br>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.<br>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.<br>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<br><br>Intraoral periapical image, each additional<br><br>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<br><br>Bitewing images, three<br><br>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.<br><br>No payment is made for multiple bitewing images taken in conjunction with a ~~panoramic image or a~~ complete series of images. | No |

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|---|---|---|---|
| Panoramic image | Patient younger than 6: PA<br><br>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<br><br>Yes, for frequency greater than 1 per 5 years<br><br>Yes, for provision within 5 years after a complete series of images |
| Cephalometric image | | | No |
| Cone beam CT view both jaws w/without cranium | 1 per 5 years per provider | No payment is made for a cone beam CT taken in conjunction with a panoramic or complete series of images nor within 5 years after a panoramic or complete series of images. | Yes, for provision within 5 years after a panoramic or complete series of images |
| Diagnostic image in conjunction with orthodontic treatment | | | No |
| Temporomandibular joint images, four to six images, including submission of patient history and treatment plan | | | No |

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| Intraoral tomosynthesis – comprehensive series of radiographic images<br><br>Intraoral tomosynthesis – bitewing radiographic image<br><br>Intraoral tomosynthesis – periapical radiographic image<br><br>Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only<br><br>Intraoral tomosynthesis – bitewing radiographic image – image capture only<br><br>Intraoral tomosynthesis – periapical radiographic image – image capture only | | Information must be submitted on or with the claim (e.g., supporting documents such as operative reports, clinical assessments, or other medical records) to identify the particular by-report procedure, service, or supply, in accordance with Chapter 5160-1 of the Administrative Code. | No<br>By report |
| 3D dental surface scan – direct<br><br>3D dental surface scan – indirect<br><br>3D facial surface scan – direct<br><br>3D facial surface scan – indirect<br><br>3D print of 3D surface scan | | Information must be submitted on or with the claim (e.g., supporting documents such as operative reports, clinical assessments, or other medical records) to identify the particular by-report procedure, service, or supply, in accordance with Chapter 5160-1 of the Administrative Code. | No<br>By report |

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|---|---|---|---|
| **TESTS AND LABORATORY EXAMINATIONS** | | | |
| ~~Biopsy of oral tissue, hard (bone, tooth)~~ | | | ~~No~~ |
| ~~Biopsy of oral tissue, soft (all others)~~ | | | ~~No~~ |
| Antigen testing for public health related pathogen including coronavirus | | Clinical Laboratory Improvements Act (CLIA) Certificate of Waiver required. | No |
| Antibody testing for public health related pathogen including coronavirus | | Clinical Laboratory Improvements Act (CLIA) Certificate of Waiver required. | No |
| Diagnostic cast | | Payment may be made only in conjunction with a treatment that requires a diagnostic cast.<br><br>A cast may be either a tangible object or a digital representation. | No |

| SERVICE DESCRIPTION | 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 and implants | Patient younger than 21: 1 per 180 days<br><br>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.<br><br>Dental prophylaxis ~~are~~ is covered 1 per 180 days for ~~pregnant women and~~ several special groups ~~such as~~including but not limited to pregnant women, foster children, and employed individuals with disabilities regardless of their age. | No |
| Dental prophylaxis, child (younger than 14), including necessary scaling or polishing to remove coronal plaque, calculus, and stains of primary or transitional teeth and implants | 1 per 180 days | No payment is made for prophylaxis performed in conjunction with gingivectomy, gingivoplasty, or scaling and root planing. | No |

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|---|---|---|---|
| Topical fluoride treatment, including sodium fluoride, stannous fluoride, or acid phosphate fluoride applied as a foam, gel, varnish, or in-office rinse<br><br>Topical application of fluoride varnish<br><br>Topical application of fluoride – excluding varnish<br><br>Application of topical fluoride varnish by a physician or other qualified health care professional when performed in a non-dental clinic or facility setting | 1 per 180 days | Coverage is limited to patients younger than 21.<br><br>Use of a polishing compound that incorporates fluoride as part of prophylaxis is not considered to be a separate topical fluoride treatment.<br><br>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.<br><br>*Use of CPT Code 99188, Application of Fluoride Varnish by a Non-Dentist*, Medicaid Advisory Letter (MAL) No. 665. | 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 or exposure.<br><br>This service may include counseling to the responsible adult present during counseling to a minor.<br><br>Documentation of tobacco use or exposure, extent of counseling session, and provision of cessation assistance or referral must be maintained in the clinical record. | No |

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| Counseling for the control and prevention of adverse oral, and systemic health effects associated with high-risk substance use - includes ingesting, injecting, inhaling, and vaping. | 2 per 365 days | Coverage is limited to patients with a history or high risk of substance use or exposure.<br><br>This service may include counseling to the responsible adult present during counseling to a minor.<br><br>Documentation of substance abuse, high risk use or exposure, extent of counseling session, and provision of cessation assistance or referral must be maintained in the clinical record. | No |
| ~~AstraZeneca Covid-19 vaccine administration - first, second dose~~ | | | ~~No~~ |
| ~~Vaccine administration - human papillomavirus - first, second, third dose~~ | | | ~~No~~ |
| Sealant-per tooth | | Coverage is limited to patients younger than 21.<br><br>Pit and fissure sealant may be applied to previously unrestored areas of permanent first and second molars. | No |

| SERVICE DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| Interim caries arresting medicament application | Application is limited to 3 times per tooth per year. | No payment is made in conjunction with a restoration or crown on the same tooth. | No |
| Space maintainer, fixed unilateral - per quadrant<br><br>Space maintainer, fixed bilateral, maxillary<br><br>Space maintainer, fixed bilateral, mandibular<br><br>Space maintainer, removable unilateral - per quadrant<br><br>Space maintainer, removable bilateral, maxillary<br><br>Space maintainer, removable bilateral, mandibular | | Coverage is limited to patients younger than 21.<br><br>Payment may be made only for a passive type of space maintainer. | No |

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|---|---|---|---|
| **RESTORATIVE SERVICES**<br>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.<br>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.<br>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).<br>A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces.<br>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.<br>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<br><br>Amalgam, two surfaces, primary or permanent<br><br>Amalgam, three surfaces, primary or permanent<br><br>Amalgam, four or more surfaces, primary or permanent | | Restoration includes polishing.<br><br>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.<br><br>Preventive restoration is not covered. | No |
| Pin retention – per tooth, in addition to amalgam restoration | 3 pins per tooth | Pin retention is reimbursed per tooth, up to a maximum of 3 pins per tooth. | No |

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|---|---|---|---|
| Resin-based composite, one surface, anterior<br><br>Resin-based composite, two surfaces, anterior<br><br>Resin-based composite, three surfaces, anterior<br><br>Resin-based composite, four or more surfaces, anterior, or involving incisal angle<br><br>Resin-based composite, one surface, posterior<br><br>Resin-based composite, two surfaces, posterior<br><br>Resin-based composite, three surfaces, posterior<br><br>Resin-based composite, four or more surfaces, posterior | | Payment includes any necessary acid etching.<br><br>Resin-based composite is permitted for all restorations of anterior teeth and for class I, II, or V restoration of posterior teeth.<br><br>Single-surface restoration must involve repair of decay that extends into the dentin.<br><br>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.<br><br>Preventive restoration is not covered. | No |
| Pin retention-per tooth, in addition to resin-based composite restoration | 3 pins per tooth | Pin retention is reimbursed per tooth, up to a maximum of 3 pins per tooth. | No |

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|---|---|---|---|
| Crown, porcelain fused to noble metal<br><br>Crown, porcelain fused to predominately base metal<br><br>Crown, porcelain/ceramic substrate | | A fused porcelain or porcelain/ceramic substrate crown may be covered for permanent teeth.<br><br>A periapical image of the involved tooth must be submitted with each PA request. | Yes |
| Re-cement/re-bond crown | ~~1 per 5 years per tooth~~ | Permanent tooth with crown only.<br><br>Re-cementation/re-bonding within the first six months of placement are included in the initial placement and are not separately reimbursed. | No |
| Crown, prefabricated porcelain/ceramic, primary tooth<br><br>Crown, prefabricated porcelain/ceramic, permanent tooth<br><br>Crown, anterior resin-based composite<br><br>Crown, prefabricated stainless-steel, primary tooth<br><br>Crown, prefabricated stainless steel, permanent tooth<br><br>Crown, prefabricated stainless steel with resin window (open face crown with aesthetic resin facing or veneer)<br><br>Crown, prefabricated esthetic coated stainless steel, primary tooth | | An anterior resin-based composite crown may be covered only for a patient younger than 21.<br><br>An anterior resin-based composite crown or a stainless steel crown with resin window may be covered for anterior teeth only.<br><br>Payment for a crown with resin window includes any necessary restoration. | No |

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| Protective restoration, primary or permanent dentition | 1 per 180 days per tooth<br><br>5 per tooth per lifetime | Direct placement of temporary restoration used to relieve pain~~,~~ and promote healing during an interim period.<br><br>Cannot be done in conjunction with interim therapeutic restoration, extraction, endodontic closure, restoration or crown on the same tooth.<br><br>5 per tooth per lifetime limit includes both protective restorations and interim therapeutic restorations.<br><br>Not a definitive restoration. | No |
| Interim therapeutic restoration, primary dentition | 1 per 180 days per tooth<br><br>5 per tooth per lifetime | Placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries.<br><br>Cannot be done in conjunction with protective restoration, extraction, endodontic closure, restoration or crown on the same tooth.<br><br>5 per tooth per lifetime limit includes both protective restorations and interim therapeutic restorations.<br><br>Not a definitive restoration. | No |
| Core buildup, including any pins when required | 1 per tooth | Coverage is limited to permanent teeth.<br><br>This service must be provided in preparation for or in conjunction with an adult crown procedure. | No |

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|---|---|---|---|
| Indirectly fabricated post and core in addition to crown<br><br>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.<br><br>A periapical image of the involved tooth must be submitted with each PA request. | Yes |
| Band stabilization – per tooth | 1 per tooth per lifetime. | | No |
| Excavation of a tooth resulting in the determination of non-restorability | | Information must be submitted on or with the claim (e.g., supporting documents such as operative reports, clinical assessments, or other medical records) to identify the particular by-report procedure, service, or supply, in accordance with Chapter 5160-1 of the Administrative Code. | No<br>By Report |
| Application of hydroxyapatite regeneration medicament – per tooth | 2 times per tooth per year | Information must be submitted on or with the claim (e.g., supporting documents such as operative reports, clinical assessments, or other medical records) to identify the particular by-report procedure, service, or supply, in accordance with Chapter 5160-1 of the Administrative Code. | No<br>By Report |

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| **ENDODONTIC SERVICES**<br>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.<br>Payment includes all diagnostic tests, evaluations, images, and postoperative treatment. | | | |
| Therapeutic pulpotomy and pulpal therapy | | Coverage is limited to patients younger than 21.<br><br>No separate payment is made when these procedures are performed in conjunction with root canal therapy.<br><br>Separate payment may be made for restoration. | No |
| Endodontic (complete root canal) therapy, excluding final restoration, anterior tooth<br><br>Endodontic (complete root canal) therapy, excluding final restoration, bicuspid<br><br>Endodontic (complete root canal) therapy, excluding final restoration, molar | | Coverage is limited to permanent teeth.<br><br>Payment for these procedures includes all diagnostic tests, evaluations, necessary images, and postoperative treatment. | No |
| Apicoectomy/periradicular services | | Coverage is limited to permanent teeth.<br><br>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 |

| SERVICE DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| Apexification/recalcification/pulpal regeneration (apical closure or calcific repair of perforations, root resorption, pulp space disinfection, etc.), initial visit<br><br>Apexification/recalcification/pulpal regeneration (apical closure or calcific repair of perforations, root resorption, pulp space disinfection, etc.), interim medication replacement<br><br>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.<br><br>Payment for these procedures includes necessary images. | No |

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| **PERIODONTIC SERVICES** | | | |
| Gingivectomy or gingivoplasty, one to three contiguous teeth per quadrant<br><br>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.<br><br>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.<br><br>No payment is made for periodontic maintenance performed in conjunction with prophylaxis nor within 30 days of scaling and root planing. | No |

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|---|---|---|---|
| Periodontal scaling and root planing, one to three teeth per quadrant<br><br>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.<br><br>The required documentation of the need for periodontal scaling and root planing must include the following items:<br><br>(1) A periodontal treatment plan and history<br><br>(2) A completed copy of an ADA periodontal chart or the equivalent that exhibits pocket depths with all six surfaces charted.<br><br>(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 |
| Removal of non-resorbable barrier | | | Yes |

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|---|---|---|---|
| **PROSTHODONTIC SERVICES**<br>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.<br>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.<br>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.<br>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:<br>(1) A copy of the resident's most recent nursing care plan;<br>(2) A copy of a consent form signed by the resident or the resident's authorized representative; and<br>(3) A dentist's signed statement describing the oral examination and assessing the resident's ability to wear dentures.<br>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.<br>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. Direct self-curing materials are not allowed. | | | |
| Complete denture, maxillary<br><br>Complete denture, mandibular<br><br>Immediate complete denture, maxillary<br><br>Immediate complete denture, mandibular | 1 per 8 years | Complete extractions must be deferred until authorization to construct the denture has been given, except in an emergency.<br><br>The immediate provision of partial dentures will not be authorized except in very unusual circumstances.<br><br>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 |

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|---|---|---|---|
| Partial denture, cast metal framework with resin base (including retentive/clasping materials, rests, and teeth), maxillary<br><br>Partial denture, cast metal framework with resin base (including retentive/clasping materials, rests, and teeth), mandibular<br><br>Partial denture, resin base (including conventional clasps, rests, and teeth), maxillary<br><br>Partial denture, resin base (including conventional clasps, rests, and teeth), mandibular<br><br>Partial denture, flexible base (including retentive/clasping materials, rests, and teeth), maxillary<br><br>Partial denture, flexible base (including retentive/clasping materials, rests, and teeth), mandibular | 1 per 8 years | PA may be granted when either:<br><br>(1) the absence of several teeth in the arch severely impairs the ability to chew or<br><br>(2) the absence of anterior teeth affects the appearance of the face.<br><br>~~A partial denture with a resin base may be covered only for a patient younger than 19.~~<br><br>A panoramic image or complete series of images, properly mounted, labeled, and readable, must be submitted with each PA request. | Yes |

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| **ORAL SURGERY**<br>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.<br>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.<br>Payment for extraction includes necessary local anesthesia, suturing, and routine postoperative care.<br>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<br><br>Surgical removal of impacted tooth, partially bony | 1 per tooth | | No, for removal of an impacted third molar, soft tissue<br>Yes, otherwise<br><br>No, for partially bony impaction |
| Surgical removal of impacted tooth, completely bony<br><br>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 |

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| 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<br>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, four or more teeth per quadrant<br><br>Alveoplasty, in conjunction with extraction, one to three teeth per quadrant<br><br>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 |
| Excisional biopsy of minor salivary glands | | No payment will be made in conjunction with another biopsy on the same date of service. | Yes |
| Biopsy of oral tissue, hard (bone, tooth) | | | No |
| Biopsy of oral tissue, soft (all others) | | | No |

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|---|---|---|---|
| Removal of benign odontogenic cyst or tumor, lesion diameter up to 1.25 cm<br><br>Removal of benign odontogenic cyst or tumor, lesion diameter greater than 1.25 cm<br><br>Removal of benign nonodontogenic cyst or tumor, lesion diameter up to 1.25 cm<br><br>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 |
| Marsupialization of odontogenic cyst | | | Yes |
| Removal of lateral exostosis (maxilla or mandible)<br><br>Removal of torus palatinus<br><br>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<br><br>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 |

| SERVICE DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| Treatment of fracture in the alveolus, closed reduction, with or without stabilization of teeth<br><br>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) buccal/ labial<br><br>Frenulectomy (frenectomy/frenotomy) lingual | | 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 |
| Guided tissue regeneration, edentulous area – resorbable barrier, per site<br><br>Guided tissue regeneration, edentulous area – non-resorbable barrier, per site | | | Yes |

| SERVICE DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| **ORTHODONTIC SERVICES**<br>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.<br>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.<br>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.<br>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.<br>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~~ treatment of the adolescent dentition, active treatment<br><br>Periodic orthodontic treatment visit | 1 calendar quarter per course of treatment<br><br>7~~8~~ calendar quarters per course of treatment | Coverage is limited to patients younger than 21.<br><br>Six items must be submitted with each PA request:<br><br>(1) Lateral and frontal photographs of the patient with lips together.<br><br>(2) Cephalometric film with lips together, including a tracing.<br><br>(3) A complete series of intraoral images.<br><br>(4) At least one diagnostic model. | Yes |

| SERVICE DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| | | (5) A treatment plan, including the projected length and cost of treatment.<br>(6) A completed Referral Evaluation for Comprehensive Orthodontic Treatment, ODM 03630 (Rev. 01/2016).<br><br>Payment for D8080 is for the initial placement visit and includes the first quarter of treatment.<br><br>Payment for D8670 will not be made in the same quarter as D8080. | |
| Comprehensive orthodontic service, retention service, per arch | 1 per arch | Coverage is limited to patients younger than 21.<br><br>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 |

| SERVICE DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| Minor treatment to control harmful habits, removable appliance<br><br>Minor treatment to control harmful habits, fixed appliance | | Harmful habits include but are not limited to thumb- or finger-sucking, tongue- thrusting, and bruxism.<br><br>Complete images, diagnostic models, or photographs of the mouth must be submitted with each PA request. | No, for removable appliances<br><br>Yes, for fixed appliances |
| Unspecified orthodontic procedure | | This service entails unusual or specialized treatment required 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.<br><br>Detailed information on the medical necessity 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 DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| **OTHER SERVICES** | | | |
| Therapeutic drug injection, single administration<br><br>Therapeutic drug injection, two or more administrations, different medications | | | No |
| Temporomandibular joint therapy<br><br>Unspecified TMD therapy | | Panoramic images, diagnostic casts, and a report of the clinical findings and symptoms must be submitted with each PA request.<br><br>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<br><br>Occlusal guard – soft appliance, full arch<br><br>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 |
| Custom sleep apnea appliance fabrication and placement<br><br>Adjustment of custom sleep apnea appliance<br><br>Repair of custom sleep apnea appliance | | | Yes |

| SERVICE DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| Reline of custom sleep apnea appliance | | | |
| Fabrication and delivery of oral appliance therapy (oat) morning repositioning device<br><br>Oral appliance therapy (oat) titration visit | | Information must be submitted on or with the claim (e.g., supporting documents such as operative reports, clinical assessments, or other medical records) to identify the particular by-report procedure, service, or supply, in accordance with Chapter 5160-1 of the Administrative Code. | No<br>By Report |
| Teledentistry, synchronous: real-time encounter | | Reported in addition to other procedures (e.g. diagnostic) delivered to the patient through teledentistry on the date of service. Teledentistry services are to be provided in accordance with Chapter 4715. of the Revised Code and Chapter 4715-23 of the Administrative Code. | No |
| Removal of implant body not requiring bone removal nor flap elevation | | | Yes |
| Guided tissue regeneration – resorbable barrier, per implant<br><br>Guided tissue regeneration – non-resorbable barrier, per implant | | | Yes |
| Replacement of restorative material used to close an access opening of a screw-retained, implant supported prosthesis, per implant | | | Yes |

| SERVICE DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| Accessing and retorquing loose implant screw - per screw | | Information must be submitted on or with the claim (e.g., supporting documents such as operative reports, clinical assessments, or other medical records) to identify the particular by-report procedure, service, or supply, in accordance with Chapter 5160-1 of the Administrative Code. | No<br>By Report |
| Behavior management | | | Yes |
| Dental case management – patients with special health care needs | | | Yes |
| Unspecified adjunctive procedure | | This service entails unusual or specialized treatment required to safeguard the health and welfare of the patient.<br>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 DESCRIPTION | QUANTITY/FREQUENCY LIMIT* | OTHER CONDITION OR RESTRICTION | PRIOR AUTHORIZATION (PA) REQUIRED |
|---|---|---|---|
| **ANESTHESIA**<br>Payment for anesthesia services includes analgesic and anesthetic agents. | | | |
| Intravenous moderate conscious sedation/ analgesia – first 15 minutes<br><br>Intravenous moderate conscious sedation/ analgesia - each subsequent 15 minute increment<br><br>Deep sedation/general anesthesia – first 15 minutes<br><br>Deep sedation/general anesthesia - each subsequent 15 minute increment | | 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.<br><br>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.<br><br>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. | No |
| Inhalation of nitrous oxide/analgesia, anxiolysis | | | Yes, for patients 21 or older |