

Dental Services Handbook Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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Medical Assistance Letters

MAL 561

Medical Assistance Letter No 561 (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 561, Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies](#)

MAL 546

Medical Assistance Letter No 546 (March 20, 2008 - Pharmacy Recordkeeping: Requirement for Tamper-Resistant Prescription Forms), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 546, Pharmacy Recordkeeping: Requirement for Tamper-Resistant Prescription Forms.](#)

MAL 539

Medical Assistance Letter No 539 (October 19, 2007 - Federal delay of requirement for use of tamper-resistant prescription pads), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 539, Changes to the Pharmacy Program Effective October 1, 2007](#)

MAL 535

Medical Assistance Letter No 535 (September 6, 2007 - Changes to the Pharmacy Program Effective October 1, 2007), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 535, Changes to the Pharmacy Program Effective October 1, 2007](#)

MAL 530

Medical Assistance Letter No 530 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Clinics Fee-for Services e-book.

[Click here to view MAL 530, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

MAL 525

Medical Assistance Letter (MAL) 525

June 7, 2007

To: Dental Group Practices
Trading Partners and Tape Intermediaries
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI.....GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform providers enrolled and billing as dental group practices in the Ohio Medicaid program that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI for group practice provider types is a unique, ten-digit, entity type 2 identifier received from the National Plan and Provider Enumeration System (NPPES). This MAL also provides information on applying for your NPI, disclosing your NPI to ODJFS, and using your NPI when submitting claims to ODJFS.

Dental group practices will also be required to use the unique (entity type 1) NPI numbers for each individual dentist providing/rendering services for the group practice on claims* submitted to ODJFS. The group practice should work with the individual dentists in the group to determine if the group will obtain the individual dentist numbers from NPPES for the practice's dentists or if the individual dentists will independently obtain their own individual dentist numbers from NPPES and then share the numbers with the group practice. For every Ohio Medicaid provider/billing number you currently have and use today for your Medicaid business, your practice must have a corresponding, unique NPI number.

After receiving the dental group NPI and the individual dentist NPI numbers and until January 1, 2008 all dental group practices conducting business with Medicaid in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) must submit both their group NPI number and their current group Medicaid provider number (now referred to as the Medicaid legacy number or the Ohio Medicaid legacy number) in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL. In addition, they must submit both the individual dentist's NPI number and the corresponding individual Medicaid legacy number in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL.* This is to create an association between these two numbers. Until January 1, 2008, claims received by ODJFS from dental group practices will continue to be accepted and processed if the claims contain a valid Medicaid legacy number or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields. Prior to January 1, 2008, claims **submitted without** an Ohio Medicaid legacy number (i.e., claims submitted only with an NPI number) in the required provider fields will be rejected or denied.*

Dental claims submitted to ODJFS on or after January 1, 2008 will be rejected and/or denied if the group and/or individual NPI number is not in the required field(s) on the claim. Dental claims submitted on or after May 23, 2008 will not require the Ohio Medicaid legacy number if ODJFS has a record of your NPI number and has linked the NPI to your Ohio Medicaid legacy number.

Dentists and dental group practices must:

- enumerate through NPPES,
- receive their NPI, and
- disclose their NPI to ODJFS immediately.

Dentists and dental group practices must be ready to submit both their NPI(s) and Medicaid legacy numbers.*

* See special instructions for paper and tape claims (below in this MAL).

I. How do I get an NPI?

Dental group practices can receive an (entity type 2) NPI number for the dental group practice and an individual (entity type 1) dentist NPI number for each dentist in the group practice by submitting an application to NPPEs. To obtain a National Provider Identifier, providers should contact NPPEs directly at <http://nppes.cms.hhs.gov> or by phone at 1-800-465-3203 (or 1-800-692-2326 (TTY)). Providers can apply for an NPI electronically or by paper.

When you apply for your dental group practice NPI, ODJFS encourages you to submit the following information with your NPI application: Ohio Medicare legacy (PIN/UPIN) number, Ohio Medicaid legacy number, taxonomy number and employer identification number (EIN). It is also very important to make it clear on the NPI application when you are applying for an NPI for the group practice and when you are applying for an individual NPI for one of the dentists in your practice.

If you are applying for a group NPI, check the box on the NPI application for "an organization that renders health care." Please submit as the primary taxonomy for the group practice either the taxonomy number **193400000X** (if you are a single specialty practice) or the taxonomy number **193200000X** (if you are a multi-specialty practice). Other dental taxonomy numbers may be given as secondary taxonomy numbers to further describe the practice and the type of specialty services provided by the practice.

If you are applying for an NPI for an individual dentist in the group (i.e., an entity type 1 NPI), check the box on the NPI application for "an individual who provides health care." Please submit as the primary taxonomy number for the individual dentist the taxonomy code that best describes the dentist's specialty. You may submit more than one dental taxonomy number.

A listing of taxonomy codes for dentists can be found at: <http://www.wpc-edi.com/codes/taxonomy>.

II. How do I bill ODJFS using the NPI?

If your practice received this MAL, at least once during the last twelve months you/your practice submitted claim(s) as a dental group practice.

Billing NPI on EDI 837 Dental Claims

The information in this section is technical but is intended to assist your practice in making the appropriate arrangements with your trading partner to receive your NPI number and to submit your NPI number on your EDI claims and other transactions. A copy of this MAL will also be issued to each EDI trading partner doing business with ODJFS.

The NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The NPI (entity type 2) assigned to the group practice must be sent with the XX qualifier in the NM108 and the group (entity type 2) NPI in the NM109 of the 2010AB (for the pay to provider information) loop and/or 2010AA (for the billing provider information) loop. Prior to January 1, 2008, the Medicaid legacy provider number assigned to the group practice must also be sent with the 1D qualifier in the secondary identification qualifier location REF01 and the group Medicaid legacy number in the secondary identification location REF02 of loops 2010AB and/or 2010AA. The rendering provider loop (2310B loop) must also be completed and contain information about the dentist who rendered the service. Group dental practices must submit the (entity type 1) NPI assigned to the individual dentist that provided the service in the NM109 of 2310B with the qualifier value of XX in the NM108 of the 2310B loop and submit the Medicaid legacy number assigned to the individual dentist in the REF02 of the 2310B loop with a 1D qualifier in the REF01 of the 2310B loop. When a group practice submits claims, the pay to numbers should always belong to the group and the rendering provider number must always be a valid individual dentist. Only one individual (entity type 1) NPI number can be associated with a (unique) individual Ohio Medicaid legacy number. An individual dentist's NPI should never be submitted to ODJFS with an individual Medicaid legacy number that belongs to another dentist or another individual, group or organizational entity.

Instructions for submitting NPI on claims for a dental group are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at: <http://ifs.ohio.gov/OHP/providers/npi.stm> (see the box titled "Trading Partner").

Billing on Claims or by Tape

** Special Instructions for Paper and Tape formats*

ODJFS is no longer accepting tape formats.

Providers using the old ADA 2000 (required until announced) must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on the old ADA 2000 will cause the claim to reject or may cause the claim to pay inappropriately.

When the new paper ADA 2006/7 is adopted by ODJFS, NPI numbers will be required on the new claim form and the processing and submission rules that apply to EDI claims will also apply to the new paper ADA 2006/7 form.

III. Is the dental group practice required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires dentists and dental group practices to obtain NPI numbers, to use their NPI on all standard transactions where a provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that dentist in a standard transaction, including transactions sent to and received from any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

IV. Is the dental group practice required to share with ODJFS the NPI numbers assigned to the group and the individual dentists that practice in the group?

Yes, the group practice must disclose the NPI number assigned to the group to ODJFS. The group practice must also disclose the NPI numbers assigned to each individual dentist that practices in the group to ODJFS, unless the individual dentist has independently disclosed his or her individual NPI number to ODJFS.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site: <http://ifs.ohio.gov/OHP/providers/npi.stm>.

V. Is the dental group practice required to share the NPI numbers assigned to the group practice or assigned to the individual dentists in the group with other entities?

Yes, dentists and dental group practices must disclose their NPI, when requested, to any entity that needs the NPI to identify that dentist/dental group practice in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans, and any other provider that needs to identify the dentist on transactions.

Pharmacies will need the appropriate individual NPI to submit as the prescribing provider on pharmacy claims; hospitals and long term care facilities (LTCF) may need your NPI to submit on hospital and LTCF claims. You are required to share the appropriate NPI with them.

VI. I heard that the date for NPI implementation has been extended. Is that true?

No, the law still requires providers of health care and health (except small) plans to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

VII. Has ODJFS deployed a contingency plan?

Yes, ODJFS has deployed a contingency plan as detailed in this MAL.

VIII. What is meant by a dual identifier period?

A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and may deny claims that are missing the plan's legacy number.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early enough for ODJFS to assist the provider in correcting any NPI-related billing problems, prior to the end of the ODJFS dual identifier period.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to December 31, 2007. During this extended period ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI). Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in non-payment or the rejection of claims.

Providers and trading partners will be notified in the event ODJFS believes the ODJFS dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

ODJFS appreciates the attention of the providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

Questions pertaining to this MAL should be addressed to:

**Bureau of Plan Operations
The Provider Services Section
P.O. Box 1461
Columbus, Ohio 43216-1461**

Toll free telephone number 1-800-686-1516

You can also obtain information about NPI as it pertains to the Ohio Medicaid program at <http://ifs.ohio.gov/OHP/providers/npi.stm>

NPI.....GET IT.....SHARE IT.....USE IT

MAL 524

Medical Assistance Letter (MAL) 524

June 7, 2007

To: Individual Dentists and Incorporated Individual Dental Practices
Trading Partners and Tape Intermediaries
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI.....GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform individual dentists and incorporated individual dental practices that are enrolled as providers in the Ohio Medicaid program and do business with ODJFS that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI for individual provider types is a unique, ten-digit, entity type 1 identifier that providers receive from the National Plan and Provider Enumeration System (NPPES). Upon receipt of their NPI and until January 1, 2008, dentists that conduct business with Medicaid in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) must submit both their individual NPI number and their current individual Medicaid provider number (now referred to as the Medicaid legacy number or Ohio Medicaid legacy number) in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL.* This is to create an association between these two numbers.

Dentists MUST enumerate through NPPES, disclose their NPI to ODJFS and bill ODJFS using both their NPI and Medicaid legacy identifiers. This MAL provides direction to providers on enumerating through NPPES, disclosing your NPI to ODJFS, and billing ODJFS using your NPI.*

Dental claims received by ODJFS before January 1, 2008 that contain a valid Ohio Medicaid legacy number, or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields, will continue to be accepted and processed. Claims submitted without an Ohio Medicaid legacy number (i.e., submitted only with an NPI number) prior to January 1, 2008 will be rejected or denied.*

Dental claims submitted to ODJFS on or after January 1, 2008 will be denied if the dentist's NPI number is not in the required field(s) on the claim. Dental claims submitted on or after May 23, 2008 will not require the Ohio Medicaid legacy number if ODJFS has a record of your NPI number and has linked the NPI to your Ohio Medicaid legacy number.

* See special instructions for paper and tape claims (below in this MAL).

I. How do I get an NPI?

Individual dentists can receive an NPI number by personally submitting an NPI application to NPPES. Or, you may arrange for your employing health care entity or place of practice to obtain an individual provider number for you. To obtain an NPI, providers should contact NPPES directly at <http://nppes.cms.hhs.gov> or by phone at 1-800-465-3203 (or 1-800-692-2326 (TTY)). Providers can apply for an NPI electronically or by paper.

When you apply for your individual NPI, ODJFS encourages you to submit the following information with your NPI application:

- Ohio Medicare legacy (PIN) number,
- Ohio Medicaid legacy number,

- taxonomy number,
- social security number, and/or
- IRS individual tax identification number (TIN).

It is also important that you make it clear that you are applying for an NPI for an individual dentist (i.e., an entity type 1 NPI) by checking the box on the NPI application for "an individual who provides health care." A listing of taxonomy codes for dentists can be found at: <http://www.wpc-edi.com/codes/taxonomy>.

II. How must my NPI relate to my Medicaid legacy number?

If your practice received this MAL, you/your practice submitted claim(s) as an individual dentist or as an incorporated individual practice to ODJFS at least once during the last twelve months. When dentists are doing business with ODJFS as an individual dentist or as an incorporated individual practice, ODJFS currently only issues an individual dentist Medicaid legacy number and expects the billing provider, pay to provider, and rendering provider to be the same provider (the individual dentist).

Services rendered by other practitioners employed by or under contract with the dentist or incorporated individual dental practice should be billed under the dentist's NPI and/or the dentist's Medicaid legacy number (when both numbers are required). This directive applies as soon as a dentist receives their NPI number and remains in effect after January 1, 2008.

Dentists must submit only the individual (entity type1) NPI assigned to them with the Ohio Medicaid legacy number that was issued to them as an individual dentist. Only one NPI number can be associated with your individual Ohio Medicaid legacy number. An individual dentist's NPI should never be submitted to ODJFS with an individual Medicaid legacy number that belongs to another dentist or person.

III. How do I bill ODJFS using the NPI?

The billing instructions contained in this MAL are for dentists who do business with ODJFS as individual dentists or as independent individual practices who have not obtained a group (entity 2 type) NPI. If you do business with ODJFS only as a member of a group practice or other provider-based practice, use the appropriate billing instructions as contained in MAL 525.

Instructions for submitting the NPI by either an individual dentist or a dental group are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at: <http://ifs.ohio.gov/OHP/providers/npi.stm> (see the box titled "Trading Partner").

Billing NPI on EDI 837 Dental Claims

The information in this section is technical but is intended to assist you in making the appropriate arrangements with your trading partner to receive your NPI number and to submit your NPI number on your EDI claims and other transactions. A copy of this MAL will also be issued to each EDI trading partner doing business with ODJFS.

The NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The dentist's NPI must be sent with the XX qualifier in the NM108 and the NPI in the NM109 of the 2010AB (for the pay to provider information) loop and/or 2010AA (for the billing provider information) loop. Prior to January 1, 2008, the dentist's Medicaid legacy provider number must also be sent with the 1D qualifier in the secondary identification qualifier location REF01 and the Medicaid legacy number in the secondary identification location REF02 of loops 2010AB and/or 2010AA. The EDI standard does not require the rendering provider loop to be completed if the rendering provider is the same as the pay to provider. For individual practices participating in Medicaid, the rendering and pay to provider is always the same. Do not send NPI information in the NM108 and NM109 nor Medicaid legacy information in the REF01 and REF02 of the rendering provider loops (2310B or 2420B respectively.)

Billing on Paper Claims or by Tape

* *Special Instructions for Paper and Tape formats*

ODJFS is no longer accepting tape formats.

At this time, ODJFS only accepts the American Dental Association (ADA) 2000 paper form. ODJFS will continue to only accept the **old** ADA 2000 until a date for the adoption of the **new** ADA 2006/7 is established and announced by ODJFS.

Providers using the old ADA 2000 (required until announced) must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on the old ADA 2000 will cause the claim to reject or may cause the claim to pay inappropriately.

When the new paper ADA 2006/7 is adopted by ODJFS, NPI numbers will be required on the new claim form and the processing and submission rules that apply to EDI claims will also apply to the new paper ADA 2006/7 form.

IV. If my sole proprietary dental practice (practices owned by one dentist) is incorporated, do I use my individual NPI number?

Although this is not currently allowed under the Ohio Medicaid program, many other health plans allow incorporated individual practices to be a group practice (of one member). The NPI provisions allow any individual practice that is incorporated to obtain an entity type 2 (group/organization) NPI and, if the individual proprietary practice is not incorporated, the practice is not eligible for a group/organization (entity type 2) NPI. When the incorporated individual practice is entitled to obtain an entity type 2 NPI, the NPI provisions require the individual dentist that owns the practice and each dentist employed by or under contract with the practice to also obtain an individual (entity 1) dentist NPI number.

You may obtain your group (entity type 2) NPI number from NPPES as instructed in Section I of this MAL. It is important that you make it clear that you are seeking the group NPI by checking the box for "an organization that renders health care." Please submit as the primary taxonomy for the group practice either the taxonomy number **193400000X** (if you are a single specialty practice) or the taxonomy number **193200000X** (if you are a multi-specialty practice). Other dental taxonomy numbers may be given as secondary taxonomy numbers to further describe the practice and the type of specialty services provided by the practice.

If your practice is an incorporated individual practice that has received, or plans to receive, an entity type 2 (group/organization) NPI, you may not submit that (entity type 2) NPI number on a claim to ODJFS until you have been issued a corresponding group Medicaid legacy number by ODJFS. Once you have received your (entity type 2) NPI for your practice, you may request a group Medicaid legacy number from ODJFS by contacting the Provider Enrollment Unit at P.O. Box 1461 Columbus, Ohio 43216-1461 or by phone at 1-800-686-1516.

Until you receive your group Medicaid legacy number from ODJFS, you must continue to bill as instructed in Section III of this MAL using only your individual NPI and Medicaid legacy number. Once you receive your group Medicaid legacy number you must bill in accordance with the instructions contained in MAL 525.

V. Why am I required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires dentists to obtain an NPI, to use it on all standard transactions where a provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that dentist in a standard transaction, including standard transactions sent to any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

VI. Am I required to share my NPI number with ODJFS?

Yes, the dentist must disclose to ODJFS the NPI number that has been assigned to the dentist. If you do not disclose your NPI to ODJFS, ODJFS will not be able to recognize you as a valid Medicaid provider. This could cause your claims to deny.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site: <http://jfs.ohio.gov/OHP/providers/npi.stm>.

VII. Am I required to share my NPI with other entities?

Yes, as stated in Section V, you are required to disclose your NPI, when requested, to any entity that needs the NPI to identify the dentist in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans and other health care providers.

Pharmacies will need your NPI to submit as the prescribing provider on claims; hospitals and long term care facilities (LTCF) may need your NPI to submit on hospital and LTCF claims. You are required to share your NPI with them.

VIII. I heard that the date for NPI implementation has been extended. Is that true?

No, the law still requires providers of health care and health (except small) plans to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

IX. Has ODJFS deployed a contingency plan?

Yes, ODJFS has deployed a contingency plan as detailed in this MAL.

X. What is meant by a dual identifier period?

A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and may deny claims that are missing the plan's legacy number.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early enough for ODJFS to assist the provider in correcting any NPI-related billing problems, prior to the end of the ODJFS dual identifier period.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to December 31, 2007. During this extended period ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI). Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in non-payment or the rejection of claims.

Providers and trading partners will be notified in the event ODJFS believes the ODJFS dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

ODJFS appreciates the attention of the providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

Questions pertaining to this MAL should be addressed to:

**Bureau of Plan Operations
The Provider Services Section
P.O. Box 1461
Columbus, Ohio 43216-1461**

Toll free telephone number 1-800-686-1516

You can also obtain information about NPI as it pertains to the Ohio Medicaid program at <http://jfs.ohio.gov/OHP/providers/npi.stm>

NPI.....GET IT.....SHARE IT.....USE IT

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.](#)

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)

MAL 473

Medical Assistance Letter No 473 (September 2, 2004 - Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 473, Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation in the Pharmacy Services e-book.](#)

MAL 462-A

Medical Assistance Letter (MAL) No. 462-A

July 8, 2004

TO: Directors, County Departments of Job and Family Services
Medical Assistance Coordinators
All Providers of Dental Services

FROM: Thomas J. Hayes, Director

SUBJECT: Update to Billing Procedures for Codes for Procedure Codes Requiring Prior Authorization

The purpose of this MAL is to issue an update to the billing procedure instructions provided in MAL 462 pertaining to dental procedure codes which require prior authorization (see table below for code listing). Only dental procedure codes requiring prior authorization which were changed to HIPPA compliant codes effective October 1, 2003 are impacted by this billing procedure update. Providers must bill the code listed on the prior authorization approval for dates of service prior to September 1, 2004. **However, for dates of service on or after September 1, 2004, providers must bill the HIPPA compliant code regardless of whether the local level code or HIPPA code is listed on the prior authorization approval.**

Dental Program Codes Requiring Prior Authorization with Code Changes Effective October 1, 2003:

Dental Program Codes Requiring Prior Authorization with Code Changes Effective October 1, 2003			
Covered Service Category	Old Local Level Code	New HIPAA Code	Code Description
Diagnostic	D0471	D0350	Oral/facial Images (includes intra/extraoral images)
Removable Prosthodontics	D5310	D5899	Unspecified removable prosthodontic procedure
Oral Surgery	D7470	D7471	Removal of lateral exostosis (maxilla or mandible)
Orthodontics	D8110	D8210	Removable appliance therapy (control harmful habits)
	D8120	D8220	Fixed appliance therapy (control harmful habits)
	Y8988	D8080	Comprehensive Orthodontic treatment of the adolescent dentition
	D8999	D8670	Orthodontic treatment visit (as part of contract)
	D8750	D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))

Other Covered Services	N/A	D5999	Unspecified maxillofacial prosthesis, by report
	D9998	D7899	Unspecified TMD therapy

The Dental Services Handbook and other provider communications are available on the Department's electronic manual site at: <http://emanuals.odjfs.state.oh.us/emanuals>

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
1-800-686-1516

MAL 462

Medical Assistance Letter (MAL) No. 462

January 8, 2004

TO: Providers of Dental Services
Directors, County Department of Human Service
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Clarification Of Dental Services Program Resin-based Composite One Surface Restoration Procedure Codes

Announcement of Billing Procedure Change for Codes with Prior Authorization Approval Numbers

This Medical Assistance Letter (MAL) has two purposes. The first is to clarify the use of procedure codes D2330 resin-based composite - one surface, anterior and D2391 resin-based composite - one surface, posterior. The second is to announce that until notified differently providers must continue to bill the old or new procedure codes as listed on the Prior Authorization (PA) approval letter. Originally in MHTL 3335-03-01 the department instructed providers to transition to the new codes by January 1, 2004.

Resin-based Composite One Surface Restoration Procedure Codes

Prior to October 1, 2003, D2330 was utilized for both anterior and class I or V posterior one surface resin-based composite restorations. Effective for dates of service on or after October 1, 2003, code D2391 was adopted for resin-based composite - one surface, posterior restorations and code D2330 was to be used only for resin-based composite - one surface, anterior restorations.

Medicaid Handbook Transmittal Letter (MHTL) No. 3335-03-01 Dental Services Handbook in the table on the last page, mistakenly, contains a reference that code D2391 is effective January 1, 2004 instead of October 1, 2003. Due to this confusion ODJFS will allow the use of either code (D2330 or D2391) for resin-based composite - one surface, posterior restorations for dates of services through December 31, 2003.

Claims submitted for resin-based composite - one surface, posterior restoration procedures utilizing Code D2330 should not have been denied by our system for this reason. Providers who have submitted claims for one surface resin-based composite - one surface, posterior restoration procedures utilizing code D2330 will not have to resubmit these claims with code D2391. For dates of service on or after January 1, 2004, code D2391 must be utilized for resin-based composite - one surface, posterior restoration procedures.

Submission Of Dental Procedure Codes With Prior Authorization Approval Numbers

Medicaid Handbook Transmittal Letter (MHTL) No. 3335-03-01 Dental Services Handbook informed dental providers of dental procedure code changes including a number of procedures requiring Prior Authorization. The MHTL further stated that after January 1, 2004 our payment system would have the ability to match PA approval numbers to the new program codes regardless of the code listed on the PA approval letter.

This system enhancement will not be in place January 1, 2004. Until further notice, dental providers are to bill the old or new dental procedure code as listed on the PA approval letter.

The Dental Services Handbook and other provider communications are available on the Department's electronic manual site at: <http://emanuals.odjfs.state.oh.us/emanuals>

The Legal/Policy Central Calendar provides a daily list of handbook and or transmittal letters issuances with links to the electronic manuals and to printer-friendly versions of the documents. Visit the Legal/Policy central calendar at: <http://www.state.oh.us/odjfs/lpc/calendar/>

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations
Provider Network Management Section

P.O. Box 1461
Columbus, Ohio 43216-1461
1-800-686-1516

MAL 460

Medical Assistance Letter No 460 (December 18, 2003 - Consumer co-payments for prescription medication requiring prior authorization), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 460, Consumer co-payments for prescription medication requiring prior authorization in the Pharmacy Services e-book.](#)

MAL 396-A

Medical Assistance Letter No. 396-A

August 24, 2001

To: All Providers Of Dental Services
From: Gregory L. Moody, Interim Director
Subject: Revised ADA Claim Form Billing Instructions

Revised Information:

- MAL 396, dated July 23, 2001, announced the department's implementation of the American Dental Association (ADA) claim form beginning August 1, 2001. The department is reissuing the billing instructions to revise the directions related to Item 13. PATIENT ID and Item 19. SUBSCRIBER/EMPLOYEE ID# or SOCIAL SECURITY NUMBER. Providers were originally instructed to place the Medicaid billing number in Item 13. The revised instructions instruct providers to place the Medicaid billing number in Item 19. This is being done to be consistent with the billing software utilized by many dental offices. The department apologizes for any inconvenience the original instructions may have caused.

General Information:

Providers must use the 1999 version 2000 form. This includes forms J588, J589, and J590. **Do not use** the 1994 versions, which include J510, J511, J512, J504. If you need to order forms, please call the ADA at 800-947-4746.

The effective date for the acceptance of these forms is August 1, 2001. However, the department will continue to accept the old ODJFS claim forms until January 1, 2002. If a provider submits a claim on one of the old ODJFS claim forms after January 1, 2002, the claim will not be processed and will be returned to the provider.

- Claims should be submitted to:

Ohio Department of Job and Family Services
P.O. Box 182243
Columbus, Ohio 43218-2243

- Providers who are submitting claims electronically are encouraged to continue with their current process.

If you have any questions pertaining to the use of the new ADA claim form, please contact:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
1-800-686-6108, option 1 or
Out of state (614) 728-3288, option1

Attachment

[Click here to view the ADA Version 2000, Dental Billing Form.](#)

[Click here to view the ADA Version 2000, Dental Billing Instructions.](#)

MAL 396

Medical Assistance Letter No. 396

July 23, 2001

To: All Providers Of Dental Services
From: Gregory L. Moody, Interim Director
Subject: ADA Claim Form Update, Effective August 1, 2001

The department is pleased to announce the implementation of the American Dental Association (ADA) claim form for all paper dental claims in addition to our electronic claims submission process. The use of the ADA claim form for paper claims is designed to simplify the billing process for dental services. In order to ensure quick and effective dental claim form implementation, this document:

- Outlines general information regarding the process implementation,
- Provides the new billing instructions, and
- Includes an example of the acceptable ADA claim form.

General Information:

- Providers must use the 1999 version 2000 form. This includes forms J588, J589, and J590. **Do not use** the 1994 versions, which include J510, J511, J512, J504. If you need to order forms, please call the ADA at 800-947-4746.
- The effective date for the acceptance of these forms is August 1, 2001. However, the department will continue to accept the old ODJFS claim forms until January 1, 2002. If a provider submits a claim on one of the old ODJFS claim forms after January 1, 2002, the claim will not be processed and will be returned to the provider.
- Claims should be submitted to:

Ohio Department of Job and Family Services

P.O. Box 182243

Columbus, Ohio 43218-2243

The P.O. Box number was incorrect in the distributed hard copy and has been corrected for the electronic version.

- Providers who are submitting claims electronically are encouraged to continue with the current process.

If you have any questions pertaining to the use of the new ADA claim form, please contact:

Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

1-800-686-6108, option 1 or

Out of state (614) 728-3288, option 1

Attachment

[Click here to view the ADA Version 2000, Dental Billing Form.](#)

Medicaid Handbook Transmittal Letters

MHTL 3335-11-02 (MITS-Related Changes to Rules in OAC Chapter 5101:3-5)

Medicaid Handbook Transmittal Letter (MHTL) No. 3335-11-02

July 28, 2011

TO: Eligible Providers of Dental Services
Medicaid Managed Care Plans
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: MITS-Related Changes to Rules in OAC Chapter 5101:3-5

The rules addressed in this transmittal letter are being amended for three reasons: (1) to comply with requirements of the five-year review process, (2) to update existing rule language, and (3) to support implementation of the Medicaid Information Technology System (MITS). MITS is Ohio Medicaid's new electronic claims submission interface and is scheduled to become operational on August 2, 2011, which is the effective date of these rules.

Rule Changes

Rule [5101:3-5-01](#), "Dental program: general and co-payment provisions," establishes criteria for eligible providers of dental services, policies governing reimbursement and co-payments, and other provisions.

Changes: A reference concerning a professional dental group in the Medicaid program has been corrected. Outdated references to: Rural Health Clinics as eligible dental providers; to the use of Medicaid legacy numbers on prescriptions; to the defunct Disability Medical Assistance (DMA) program; and to the limited adult dental benefit in effect from January 1, 2006, through June 30, 2008, have been removed. Instructions on how to submit a prior authorization request for dental services in MITS have been added in accordance with the provisions of rule 5101:3-1-31. Terminology used in the rule has been updated, and a typographical error has been corrected.

Rule [5101:3-5-10](#), "Dental program: covered orthodontic services and limitations," establishes coverage policies for and limitations on orthodontic services in the dental program.

Changes: Language has been added to describe how a prior authorization request for orthodontic services must be submitted in MITS. A typographical error has been corrected.

Note: All prior authorization requests must be submitted through the ODJFS web portal. Paper prior authorization requests will no longer be processed as of the effective date of this rule not the December 7, 2010 date currently mentioned in paragraph (C) (2) of this rule. Form JFS 03612, "Prior Authorization for Dental Services," will no longer be accepted; instead, the necessary information will be entered online through the ODJFS web portal. Additional documentation necessary to complete a prior authorization request that cannot be uploaded and submitted through the web portal (such as X-ray images and dental molds) must be submitted separately.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

ODJFS maintains an "electronic manuals" web page of the department's rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select the appropriate service provider type or handbook.

- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

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To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone (800) 686-1516

MHTL 3335-11-01 (Dental Program Rule Changes Due to 2011 CDT Changes)

Medicaid Handbook Transmittal Letter (MHTL) No. 3335-11-01

March 28, 2011

TO: Eligible Providers of Dental Services
Medicaid Managed Care Plans
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Dental program rule changes due to 2011 Current Dental Terminology (CDT) changes

Summary

The rules addressed in this transmittal letter have been amended to comply with requirements of the five-year review process and to adopt the new CDT 2011-2012 codes. There is no change in codes for procedures covered by the Ohio Medicaid program. However, the description of certain covered codes has been updated. These rules are effective March 30, 2011 and replace emergency versions of the rules that were effective December 30, 2010.

Rule Changes

Rule 5101:3-5-06, "Dental program: covered endodontic services and limitations" establishes coverage policies for and limitation on endodontic services in the dental program.

Changes: This rule has been amended to revise the nomenclature of apexification/recalcification procedures, interim and initial visit, to include the terms "pulpal regeneration" and "pulp space disinfection" in (E)(1)(a) and (b). The word "pulpectomy" has been removed from (E)(1)(i) and the word "is" is being replaced by "may include" in (E)(1)(ii). Additionally, outdated rule language has been deleted from paragraph (A).

Rule 5101:3-5-09, "Dental program: covered oral surgery services and limitations" establishes coverage policies for and limitation on oral surgery services in the dental program.

Changes: This rule has been amended to revise the nomenclature of the frenulectomy procedure to include "also known as" and "not incidental to another procedure" in (L)(1). Additionally, outdated rule language in paragraph (A) and an outdated rule reference in paragraph (M) has been deleted.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

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Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

MHTL 3335-09-02 (Community Provider Fee Decrease)

Medicaid Handbook Transmittal Letter (MHTL) No. 3335-09-02

January 8, 2010

TO: All Eligible Dentists
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately \$19,736,109.

OAC rule [5101:3-1-60](#), entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately \$1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately \$82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately \$16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately \$1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately \$335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately \$569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately \$4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately \$21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from \$185.02 to \$185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from \$202.00 to \$210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule [5101:3-4-21.2](#), entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately \$194,457.

OAC rule [5101:3-5-02](#), entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$200,946.

OAC rule [5101:3-5-04](#), entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$491,720.

OAC rule [5101:3-10-05](#), entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately \$272,067.

OAC rule [3-10-26](#), entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately \$285,921.

OAC rule [5101:3-12-05](#), entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately \$5,676,688.

OAC rule [5101:3-12-06](#), entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The

reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately \$4,231,876.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate service provider type or handbook;
- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: <http://www.odjfs.state.oh.us/subscribe/>.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3335-09-01

Medical Handbook Transmittal Letter (MHTL) No. 3335-09-01

April 3, 2009

TO: All Providers of Dental Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Ohio Medicaid Program Adoption of CDT-9 Procedure Codes

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to notify dental providers that the department has reviewed and adopted the new CDT-9 codes. There is no change in codes for procedures covered by the Ohio Medicaid program, however, the description of certain covered codes has been updated.

Rule [5101:3-5-04](#) entitled "Dental program: covered preventive services and limitations" is being amended to revise the nomenclature of procedure "topical application of fluoride (prophylaxis not included) - child" to "topical application of fluoride - child." Additionally a grammatical change has been made in paragraph (A)(1)(c) but the content is the same.

Rule [5101:3-5-06](#) entitled "Dental program: covered endodontic services and limitations" is being amended to revise the nomenclature of complete root canal therapy procedures codes to include the terms endodontic therapy and tooth. In (C) (4) and (5) the word "covered" is replacing the word "authorized" to clarify that prior authorization is not required for these complete root canal endodontic therapy procedures. Additionally (E)(1)(b)(i) has been changed from a lettered paragraph to an unlettered paragraph but the content is the same.

Rule [5101:3-5-07](#) entitled "Dental program: covered periodontic services and limitations" is being amended to revise the nomenclature of procedure "gingivectomy or gingivoplasty - per quadrant" to "gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant."

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

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- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Paper Distribution:

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed

copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, OH 43216-1461

MHTL 3335-08-01

Medical Handbook Transmittal Letter (MHTL) No. 3335-08-01

July 18, 2008

TO: All Providers of Dental Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelly, Director

SUBJECT: Medicaid Rules for Adult Dental Services Restoration and Fee Increase

This letter explains the restoration of the adult dental benefit and a provider fee increase, both of which are effective for dates of service on and after July 1, 2008.

Dental Benefit Changes (OAC rules 5101:3-5-01, 5101:3-5-02, 5101:3-5-04, 5101:3-5-05, 5101:3-5-06, 5101:3-5-07, 5101:3-5-08, 5101:3-5-09, 5101:3-5-10 and 5101:3-5-11)

The Medicaid adult (21 and older) dental program will cover two annual routine exams and cleanings, x-rays, fillings, extractions and oral surgery services, crowns, posts and related services, full and partial dentures and related services, surgical incisions, endodontics including root canals and general anesthesia.

Rule 5101:3-5-01 entitled "Dental program: general provisions" is being amended to remove language regarding a limited adult dental benefit. Language has been added recognizing advanced practice nurses as authorized prescribers of drugs, and requiring providers to utilize their national provider identifier number (NPI) on prescriptions.

Additionally, language regarding the prior authorization of certain dental services and the required forms for prior authorization has been added. Forms JFS 03612 "Prior Authorization For Dental Services" and JFS 03630 "Referral Evaluation Criteria for Comprehensive Orthodontic Treatment" are being amended to include fields for provider NPI and Medicaid Legacy ID numbers

Rule 5101:3-5-02 entitled "Dental program: covered diagnostic services and limitations" is being amended to remove language limiting coverage of the periodic oral evaluation to once every three hundred and sixty five days for consumers twenty-one years of age and older and the elimination of coverage for temporomandibular joint films for consumers age twenty-one years and older. Reference to OAC rule 5101:3-28-04 regarding coverage of evaluations for the purpose of adjusting dentures has been added.

Rule 5101:3-5-04 entitled "Dental program: covered preventive services and limitations" is being amended to remove language limiting the coverage of dental prophylaxis to once every three hundred and sixty five days and removing language eliminating coverage for space maintenance appliances for consumers twenty-one years of age and older.

Rule 5101:3-5-05 entitled "Dental program: covered restorative services and limitations" is being amended to remove language eliminating coverage of crowns, posts and related services for consumers twenty-one years of age and older. Language clarifying program coverage and reimbursement for multiple surface, separate restorations has been added.

Rule 5101:3-5-06 entitled "Dental program: covered endodontic services and limitations" is being amended to remove language limiting coverage of endodontic services to anterior root canal procedures for consumers twenty-one years of age and older.

Rule 5101:3-5-07 entitled "Dental program: covered periodontic services and limitations" is being amended to remove language eliminating coverage of periodontic services for consumers twenty-one years of age and older.

Rule 5101:3-5-08 entitled "Dental program: covered removable prosthodontic services and limitations" is being amended to remove separate reimbursement for additional clasps required for partial dentures.

Rule 5101:3-5-09 entitled "Dental program: covered oral surgery services and limitations" is being amended to remove language limiting coverage of oral surgery services to simple extractions and surgical procedures covered as physician services utilizing current procedural terminology (CPT) codes for consumers twenty-one years of age and older. Additionally, terminology is amended to clarify the billing for the surgical removal of a supernumerary tooth.

Rule 5101:3-5-10 entitled "Dental program: covered orthodontic services and limitations" is being amended to remove language eliminating coverage for fixed and removable appliance therapy services for consumers twenty-one years of age and older. Language specifying the required forms for prior authorization of orthodontic services has been added.

Rule 5101:3-5-11 entitled "Dental program: other covered services and limitations" is being amended to remove language eliminating coverage of temporomandibular therapy services for consumers twenty-one years of age and older.

Medicaid Reimbursement (OAC rule 5101:3-1-60)

The Department is pleased to announce that the payment rates for dental codes will be increased by an aggregate total of three percent. Effective for dates of service on and after July 1, 2008, a two percent across the board fee increase is being implemented for all covered CDT codes. An additional one percent rate increase has been distributed equally between the covered denture services CDT codes.

These Medicaid maximum changes are applicable to claims for consumers remaining in traditional Medicaid (Medicaid fee-for-service) who have not transitioned to a Medicaid managed care plan (MCP). For claims for consumers in a Medicaid MCP, providers are reimbursed according to negotiated rates established between the MCP and the provider. MCP providers should refer to their contract with the MCP to determine how the Medicaid maximum updates and policy revisions in this MHTL and in the Medicaid reimbursement rule 5101:3-1-60 will affect their MCP reimbursement. Contracting questions should be directed to the applicable MCP.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu; and
- (4) Selecting the link to Appendix DD located near the bottom of the web page.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Paper Distribution:

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461
Columbus, OH 43216-1461

Attachments

[Click here to view the JFS 03630 form](#)

MHTL 3335-06-01

Medical Handbook Transmittal Letter (MHTL) No. 3335-06-01

December 15, 2006

TO: All Providers of Dental Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Ohio Medicaid Program Adoption of CDT-2007/2008 Procedure Codes

RULE AND PROGRAM CHANGES ARE EFFECTIVE JANUARY 1, 2007.

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to notify dental providers that the Department has reviewed and adopted the new CDT-2007/2008 codes and has amended OAC rule 5101:3-5-02 Dental program: covered diagnostic services and limitations to include coverage of D0273 bitewings - three films effective for dates of service on and after January 1, 2007.

CDT D0273 bitewings - three films is subject to the same Medicaid coverage and limitations as other covered bitewing films for children and adult consumers.

Provider handbooks, program rules, billing instructions and other provider communications are available on the Department's electronic manual site at:

<http://emanuals.odjfs.state.oh.us/emanuals>

If you do not have internet access, you may request a paper copy of the new OAC rule 5101:3-5-02 mentioned in this MHTL by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516

MHTL 3335-05-01

Medical Handbook Transmittal Letter (MHTL) No. 3335-05-01

December 28, 2005

TO: All Providers of Dental Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: MEDICAID AND DISABILITY ASSISTANCE (DMA) RULES FOR DENTAL SERVICES AND CO-PAYMENT PROGRAM

RULE AND PROGRAM CHANGES ARE EFFECTIVE JANUARY 1, 2006.

The dental services rules have been amended in accordance with Am. Sub. House Bill 66 which authorized a modified dental benefit for Medicaid consumers 21 years of age and older. The bill also included a requirement to implement a consumer co-payment for covered dental services for non-institutionalized and non-pregnant adults. These changes also impact the Disability Medical Assistance (DMA) coverage for dental services.

These changes to the Medicaid and DMA dental benefit and co-payment program are effective for dates of service on and after January 1, 2006.

MEDICAID DENTAL PROGRAM CHANGES

(OAC 5101:3-5-01, 5101:3-5-02, 5101:3-5-03, 5101:3-5-04, 5101:3-5-05, 5101:3-5-06, 5101:3-5-07, 5101:3-5-08, 5101:3-5-09, 5101:3-5-10, 5101:3-5-11)

The Medicaid adult dental program for consumers 21 years of age and older will cover one annual routine exam and cleaning, x-rays, fillings, simple extractions, fractures, full and partial dentures and related services, surgical incisions, root canals for anterior teeth and general anesthesia.

In addition, a fee reduction for all Medicaid dental services of 2% and an additional 5% for denture services for all consumers, children and adults, will be implemented.

A table comparing the current Medicaid dental coverage for adult consumers to the coverage effective on and after January 1, 2006 is available at the following site under HIPAA compliant codes:

<http://jfs.ohio.gov/ohp/infodata/hipaa.stm>

Prior authorizations for adult dental services that will no longer be covered will expire effective December 31, 2005 regardless of the date on the PA letter. PA submissions for adult dental services that will no longer be covered for adults will continue to be reviewed for dates of service through December 31, 2005.

DISABILITY MEDICAL ASSISTANCE (DMA) DENTAL PROGRAM CHANGES (OAC 5101:3-23-01)

The DMA dental program for consumers 21 years of age and older will be limited to simple extractions and x-rays necessary to support the need for the extraction.

In addition, a fee reduction for DMA dental services of 2% for all consumers, children and adults, will be implemented.

MEDICAID AND DMA PROGRAM DENTAL CO-PAYMENTS

(OAC 5101:3-1-09)

Effective for dates of service on and after January 1, 2006, consumers who are eligible for the Medicaid or the Disability Medical Assistance programs will be subject to a \$3.00 co-payment per date of service for covered dental services, with the exception of those exemptions outlined below. When a co-payment is applicable the dental provider is responsible for collecting the co-payment, and the department will reduce the provider's reimbursement by the amount of the co-payment.

Co-payments must not be charged by a dental provider if the consumer is:

-under age 21, or

-pregnant or in the post-partum period (The post-partum period is the immediate postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the sixty day period following termination of pregnancy ends.), or

- in a nursing home or intermediate care facility for the mentally retarded, or

- receiving hospice care, or

- a member of a Medicaid managed care program.

Co-payment claims processing instructions have been established to indicate that a consumer and the resulting covered services are exempt from co-payment by utilizing the first ten characters in the remarks/claim note fields on dental claim types.

These instructions are available at the following site under Supplemental Billing Instructions regarding co-payments for the Dental, Professional and Institutional Claim Formats:

<http://jfs.ohio.gov/ohp/infodata/hipaa.stm>

Consumers subject to co-payment, who are unable to pay their co-payment at the time their service is provided, may indicate their inability to pay and obtain their services without paying the co-payment. No provider may deny services to a consumer on account of the consumer's inability to pay the co-payment. The consumer remains liable for the co-payment and the dental provider may bill the consumer for the co-payment or request payment for a prior uncollected co-payment.

Provider handbooks, program rules, billing instructions and other provider communications are available on the Department's electronic manual site at:

<http://emanuals.odjfs.state.oh.us/emanuals>

If you do not have internet access, you may request a paper copy of the new OAC rules 5101:3-5-01 through 11, 5101:3-23-01 or 5101:3-1-09 mentioned in this MHTL by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3335-04-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3335-04-01

December 21, 2004

TO: All Providers of Dental Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Ohio Medicaid Program Acceptance of Digital Diagnostic Casts Effective January 1, 2005
Adoption of CDT-5 Procedure Codes

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to notify dental providers that the department will begin accepting digital diagnostic casts (D0470) for the evaluation of treatments that require diagnostic casts for prior authorization effective January 1, 2005.

Additionally, the department has reviewed and adopted the new CDT-5 codes, however, there is no change in codes for procedures covered by the Ohio Medicaid program.

In response to the requests of dental providers, the department reviewed and evaluated digital diagnostic casts and has agreed to accept them from providers utilizing this technology as an alternative to traditional plaster or stone diagnostic casts. Program processing, approval and reimbursement for diagnostic casts (D0470) will be the same regardless of whether they are submitted in digital format or as a physical cast.

Providers should submit the digital diagnostic cast, on floppy disc or CD-ROM, with all other documentation required for prior authorization requests. The digital cast will not be returned unless it is clearly marked to be returned to the provider.

Provider handbooks, billing Instructions and other provider communications are available on the Department's electronic manual site at: <http://emanuals.odjfs.state.oh.us/emanuals>

The Legal/Policy Central Calendar provides a daily list of handbook and or transmittal letters issuances with links to the electronic manuals and to printer-friendly versions of the documents. Visit the legal/Policy central calendar at: <http://www.odjfs.state.oh.us/lpc/calendar/>

Providers without access to the internet can request a paper copy of provider communications by submitting a completed copy of the ODJFS, Health Plan Provider Update request Form (JFS 03400) which is attached.

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations
Provider Network management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

In State: 1-800-686-6108 (toll free) or (614) 728-3288

Out-of-State: (614) 728-3288

MHTL 3335-03-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3335-03-01

October 27, 2003

TO: All Providers of Dental Services
Directors, County Department of Human Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Dental Services Handbook

EFFECTIVE DATES: ALL CHANGES ARE EFFECTIVE OCTOBER 1, 2003, EXCEPT MULTIPLE SURFACE RESIN-BASED POSTERIOR RESTORATIONS COVERAGE WHICH IS EFFECTIVE JANUARY 1, 2004

The department has updated the dental handbook to clarify program guidelines, make changes to prior authorization requirements, become compliant with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and to add coverage for multiple surface resin-based posterior restorations.

This transmittal obsoletes all previously issued Chapter 3335 Dental Handbook materials.

Clarification Of Program Guidelines

DEN.1101. DIAGNOSTIC SERVICES (5101:3-5-02 Dental program: covered diagnostic services and limitations.) Revisions have been made to clarify program coverage guidelines for radiographs including periapical films, bitewing films and panoramic films.

DEN.1004 ENDODONTIC SERVICES (5101:3-5-06 Dental Program: covered endodontic services and limitations.) and DEN.1107. ORAL SURGERY SERVICES (5101:3-5-09 Dental program: covered oral services surgery services and limitations.) In conjunction with removal from prior authorization requirements, program coverage guidelines have been clarified for complete root canal and removal of tooth-partially bony procedures.

To be HIPAA compliant, surgical removal of supernumerary tooth procedures (Y7255), for dates of service on or after October 1, 2003, must be billed by paper hardcopy on available non-837 claim transactions using this local program code until a CDT code is assigned for this procedure. Prior authorization (PA) requirements and pricing by report remain in effect for this code.

Prior Authorization Changes

DEN.1104 ENDODONTIC SERVICES (5101:3-5-06 Dental program: covered endodontic services and limitations.) Requirements for prior authorization (PA) are removed for root canal therapy procedures (D3310, D3320, D3330).

DEN.1107 ORAL SURGERY SERVICES (5101:3-5-09 Dental program: covered oral surgery services and limitations.) Requirements for prior authorization (PA) are removed for removal of impacted tooth-partially bony procedures (D7230).

Effective October 1, 2003, there will be dental procedure code changes. Some of these procedures require prior authorization (D0471, D5310, D7470, D8110, D8120, Y8988, D8999, D8750, D5999 and D9998). For claims submitted for payment prior to January 1, 2004, bill the procedure code on the PA approval letter. For claims submitted for payment on or after January 1, 2004, with a date of service prior to January 1, 2004, bill the code listed on the PA approval letter. If the date of service is January 1, 2004 or after, bill the new code regardless of the code listed on the PA approval letter. After January 1, 2004 our payment system will have the ability to match PA approval numbers to the new codes regardless of the code listed on the PA approval letter. For example, if a prior authorization number was obtained on September 25, 2003 for the removal of lateral exostosis (maxilla or mandible) and the procedure was performed on October 7, 2003, D7470 should be submitted on the claim form. If in this example, the procedure were to be performed January 4, 2004, D7471 should be submitted on the claim form.

HIPAA COMPLIANT CODING CHANGES

HIPAA requires the use of standard code sets. These code sets include the ADA CDT-4 coding system and AMA CPT coding system. The following table identifies the current program codes and the crosswalk to the new codes to use for dates of service on or after October 1, 2003.

Dental Program Code Changes Effective October 1, 2003			
* Codes requiring Prior Authorization + Codes billed By Report			
Covered Service Category	Current Code	New Code	New Code Description
Diagnostic	D0471*	D0350*	Oral/facial Images (includes intra/extraoral images)
Preventive	Y1352	D1351	Sealant - per tooth
Restorative	D2110	D2140	Amalgam - one surface, primary or permanent
	D2120	D2150	Amalgam - two surfaces, primary or permanent
	D2130	D2160	Amalgam - three surfaces, primary or permanent
	D2330	D2391	Resin-based composite - one surface posterior
	D5310*	D5899*	Unspecified removable prosthodontic procedure
Oral Surgery	D7110	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
	D7120	D7140	
	D7130	D7140	
	D7470*	D7471*	Removal of lateral exostosis (maxilla or mandible)
	D7670+	D7671+	Alveolus - open reduction, may include stabilization of teeth
Orthodontics	D8110*	D8210*	Removable appliance therapy (control harmful habits)
	D8120*	D8220*	Fixed appliance therapy (control harmful habits)
	Y8988*	D8080*	Comprehensive Orthodontic treatment of the adolescent dentition
	D8999*	D8670*	Orthodontic treatment visit (as part of contract)

	D8750*	D8680*	Orthodontic retention (removal of appliances, construction and placement of retainer(s))
Other Covered Services	N/A	D5999*	Unspecified maxillofacial prosthesis, by report
	D9998*	D7899*	Unspecified TMD therapy

Multiple Surface Resin-based Posterior Restorations Coverage

DEN.1103. RESTORATIVE SERVICES (5101:3-5-05 Dental Program: covered restorative services and limitations.) Effective for dates of service on or after January 1, 2004, resin-based composite restorations shall be allowed for Class II restorations on posterior teeth and two, three and four or more surface posterior restorations. Posterior resin-based restorations will be reimbursed at the same fee (medicaid maximum reimbursement) as the comparable amalgam restoration. The following table lists these codes.

Dental Program Covered Resin-based Composite Posterior Restoration		
Codes Effective January 1, 2004		
Current Code	New Code	New Code Description
D2330	D2391	Resin-based composite - one surface, posterior
NEW	D2392	Resin-based composite - two surfaces, posterior
NEW	D2393	Resin-based composite - three surfaces, posterior
NEW	D2394	Resin-based composite - four or more surfaces, posterior

Code D2330 should continue to be used for resin-based composite - one surface, anterior restoration procedures.

The new dental rules are available on the Department's electronic manual site at: <http://dynaweb.odjfs.state.oh.us:6336/dynaweb>.

The Legal/Policy Central Calendar provides a daily list of handbook and/or transmittal letters issuances with links to the electronic manuals and to printer-friendly versions of the documents. Visit the Legal/Policy central Calendar at: <http://www.odjfs.state.oh.us/lpc/calendar/index.asp>

Providers without access to the internet can request a paper copy of the dental handbook by submitting a copy of the ODJFS, Health Plan Provider Update Request Form ([JFS 03400](#)), which is attached.

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations
 Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

In State: 1-800-686-6108 (toll free) or (614) 728-3288

Out-of-State: (614) 728-3288

MHTL 3335-99-4

Medicaid Handbook Transmittal Letter (MHTL) No. 3335-99-4

January 11, 2000

TO: All Providers of Dental Services
Directors, County Departments of Human Services
Medical Assistance Coordinators

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Medicaid Handbook, Chapter 3335, Dental Services

Attached to this Medicaid Handbook Transmittal Letter (MHTL) is a copy of Chapter 3335, Dental Services. This replaces all previously issued Chapter 3335 handbook material.

All dental services handbook material issued prior to January 1, 2000 should be discarded and replaced with the attached Chapter 3335.

The following is a summary of changes that have been made to the dental services program.

Fee Increase

The Department is pleased to announce that fees for dental services have been updated for procedures performed on and after January 1, 2000. This MHTL contains the [new reimbursement rates for dental services](#). Please note that these fee increases will be effective January 1, 2000.

New Address for Claims Submission

The department has a new PO box number to submit hard copy ODHS 6780 claim forms. The new PO box number replaces the old address which was the Dept. of Human Services, PO box 2644, Columbus, Ohio 43266-0044. The new address to be used immediately is:

Ohio Department of Human Services
P.O. Box 182243
Columbus, Ohio 43218-2243

Policy Changes

The procedure code for the initial oral examination D0110 will be changed to D0150 to match the CDT-3 definition for comprehensive oral evaluation. The procedure code for the emergency exam D0130 will be changed to D0140 to match the CDT-3 definition for limited oral evaluation-problem focused. These new codes will be accepted on January 1, 2000. The codes D0110 and D0130 will be accepted through March 31, 2000 while providers transition to the use of the new codes. After March 31, 2000 the codes D0110 and D0130 will no longer be accepted and the provider must submit claims using the new codes D0150 for comprehensive oral exam and D0140 for limited oral evaluation-problem focused.

The following procedure codes have been added to the list of covered procedures to be effective January 1, 2000:

D2161 Amalgam, four or more surfaces
D3351 Apexification - interim medication replacement
D3352 Apexification - final visit
D5211 Maxillary partial denture (for patients under age 18)
D5212 Mandibular partial denture (for patients under age 18)

These new procedure codes and all other policy changes are underlined in Chapter 3335.

The Billing Instructions in this new handbook have been revised to include instructions for the Claim Credit Reversal form ODHS 6768. The only other changes that affect billing are the changes and additions of procedure codes mentioned in this MHTL.

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations

Provider Relations Section

P.O. Box 1461

Columbus, OH 43266-0161

In-State: 1-800-686-6108 (toll-free) or (614) 728-3288

Out-of-State: (614) 728-3288

DENTAL FEES EFFECTIVE JANUARY 1, 2000:

PROC CODE	OLD RATES	NEW RATES
D0110	\$14.67	\$26.35
D0120	\$11.68	\$17.08
D0130	\$11.68	\$22.58
D0140	New	\$22.58
D0150	New	\$26.35
D0210	\$45.00	\$60.00
D0220	\$3.75	\$5.00
D0230	\$3.75	\$5.00
D0240	\$8.67	\$12.00
D0250	\$10.35	\$13.46
D0270	\$3.75	\$5.00
D0272	\$7.50	\$10.00
D0274	\$15.00	\$20.00
D0321	\$51.77	\$51.77
D0330	\$30.00	\$46.32
D0340	\$41.41	\$60.00
D0470	\$14.00	\$22.02
D0471	\$9.00	\$12.31
D1110	\$21.29	\$34.13
D1120	\$15.59	\$20.00

D1203	\$10.35	\$15.00
D1351	\$18.00	\$22.00
D1510	\$78.10	\$113.71
D1515	\$119.66	\$163.28
D1520	\$85.91	\$125.08
D1525	\$98.05	\$133.79
D2110	\$27.20	\$40.00
D2120	\$33.90	\$54.00
D2130	\$55.00	\$65.00
D2140	\$27.20	\$40.00
D2150	\$33.90	\$54.00
D2160	\$55.00	\$65.00
D2161	New	\$76.54
D2330	\$33.18	\$51.21
D2331	\$38.76	\$63.49
D2332	\$42.34	\$76.62
D2335	\$63.33	\$94.95
D2752	\$234.00	\$427.29
D2930	\$63.33	\$101.92
D2931	\$63.33	\$116.51
D2933	\$92.14	\$153.00
D2951	\$8.99	\$16.49
D2952	\$69.00	\$136.32
D3220	\$35.70	\$63.74
D3310	\$124.00	\$247.63
D3320	\$150.00	\$298.10
D3330	\$202.00	\$379.02
D3351	\$70.00	\$60.00
D3352	New	\$40.00

D3353	New	\$40.00
D3410	\$89.00	\$178.00
D4210	\$118.00	\$197.20
D5110	\$243.00	\$400.00
D5120	\$243.00	\$400.00
D5211	New	\$205.00
D5212	New	\$205.00
D5213	\$295.00	\$540.25
D5214	\$295.00	\$540.03
D5310	\$29.00	\$40.00
D5510	\$37.42	\$50.00
D5520	\$23.73	\$40.00
D5610	\$33.86	\$50.00
D5620	\$46.07	\$78.00
D5630	\$43.16	\$74.00
D5640	\$23.73	\$40.00
D5650	\$33.76	\$40.00
D5660	\$46.05	\$74.00
D5750	\$98.00	\$175.51
D5751	\$98.00	\$175.80
D5760	\$76.00	\$140.00
D5761	\$76.00	\$140.00
D7110	\$31.25	\$52.45
D7120	\$30.15	\$48.34
D7130	\$30.00	\$60.00
D7220	\$51.00	\$102.00
D7230	\$86.00	\$151.46
D7240	\$115.00	\$188.80
D7241	\$135.00	\$200.00

D7280	\$83.00	\$152.30
D7285	\$75.00	\$150.00
D7286	\$64.82	\$130.00
D7310	\$50.30	\$99.06
D7320	\$60.32	\$120.64
D7960	\$71.00	\$119.13
D8110	\$140.00	\$205.00
D8120	\$250.00	\$300.00
D8210	\$140.00	\$205.00
D8220	\$161.00	\$230.00
D8750	\$140.00	\$205.00
D8999	\$192.00	\$261.94
D9220	\$83.10	\$95.65
D9998	\$370.00	\$482.50
Y1352	\$18.00	\$22.00
Y8988	\$527.00	\$624.00

CODES THAT ARE PRICED "BY REPORT":

Codes that are priced "By Report"		
D7270	B.R.	B.R.
D7450	B.R.	B.R.
D7451	B.R.	B.R.
D7460	B.R.	B.R.
D7461	B.R.	B.R.
D7510	B.R.	B.R.
D7520	B.R.	B.R.
D7670	B.R.	B.R.
D9610	B.R.	B.R.

CODES THAT ARE PRICED IN PRIOR AUTHORIZATION:

Codes that are priced in Prior Authorization

D5955	P.A.	P.A.
D7250	P.A.	P.A.
D7470	P.A.	P.A.
D7970	P.A.	P.A.
D9999	P.A.	P.A.
Y7255	P.A.	P.A.

Miscellaneous Medicaid Handbook Transmittal Letters

MHTL 3334-13-04

Medicaid Handbook Transmittal Letter (MHTL) No. [3334-13-04](#) is maintained in the General Information e-book.

MHTL 3334-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. [3334-09-02](#) is maintained in the General Information e-book.

Dental Program Rules

MHTL 3335-11-02

Effective Date: August 2, 2011

Most Current Prior Effective Date: July 1, 2008

- (A) Eligible providers of dental services.
- (1) All individuals currently licensed under state of Ohio law to practice dentistry are eligible to participate in the Ohio medicaid program as a dental provider upon execution of the "Medicaid Provider Agreement" according to rule 5101:3-1-17.2 of the Administrative Code.
 - (2) A ~~dentist's professional association~~ professional dental group (group dental practice) is also considered eligible as a group dental practice if organized ~~under sections 1785.01 to 1785.08 of the Revised Code,~~ in accordance with 5101:3-1-17 of the Administrative Code, for the sole purpose of providing professional dental services.
 - (3) Dentists practicing and serving Ohio medicaid consumers outside of Ohio must be licensed by the dental examining board in their own state and must complete the "Medicaid Provider Agreement."
 - (4) Other eligible providers of dental services include, but are not limited to, the following medicaid providers if the providers employ or have under contractual arrangement individuals licensed to practice dentistry:
 - (a) Fee-for-service ambulatory health care clinics as defined in Chapter 5101:3-13 of the Administrative Code.
 - (b) Outpatient health facilities as defined in Chapter 5101:3-29 of the Administrative Code.
 - ~~(c) Rural health clinics as defined in Chapter 5101:3-16 of the Administrative Code.~~
 - ~~(d)~~(c) Federally qualified health centers as defined in Chapter 5101:3-28 of the Administrative Code.
- (B) General anesthesia.
- (1) General anesthesia is reimbursable only when performed by a dentist who has an "Ohio state dental board permit."
 - (2) Dentists practicing and serving Ohio medicaid consumers outside the state of Ohio must meet the requirements of the dental examining board in their own state for administering general anesthesia.
- (C) Drugs.
- (1) Drugs are provided under the medicaid program only upon written prescription of a physician, physician assistant, advanced practice nurse, or dentist.
 - (2) Providers are required to print or stamp their ~~seven-digit medicaid legacy number and~~ ten digit national provider identifier (NPI) number on the prescription blank or give their provider numbers to the pharmacist on prescriptions telephoned directly to the pharmacy.
 - ~~(3) Reimbursement for the cost of drugs for take-home use prescribed and dispensed by dentists shall be consistent with rule 5101:3-4-13 of the Administrative Code.~~
- (D) Co-payments (except for medicaid consumers enrolled in the medicaid managed health care program). For dates of service on or after January 1, 2006, the department has adopted a medicaid co-payment of three dollars per date of service per provider in accordance with rules 5101:3-1-09 and 5101:3-1-60 of the Administrative Code. Services provided to a consumer on the same date of service by the same provider are subject only to one co-payment.

- (1) ~~For dates of service on or after January 1, 2006, the department has adopted a medicaid co-payment of three dollars per date of service per provider in accordance with rules 5101:3-1-09 and 5101:3-1-60 of the Administrative Code. Services provided to a consumer on the same date of service by the same provider are subject only to one co-payment.~~
- (2) ~~The dental co-payments set forth in this rule also apply to consumers who are eligible under the disability medical assistance (DMA) program in accordance with rule 5101:3-23-01 of the Administrative Code, when the dental services provided are covered under the DMA program in accordance with Chapter 5101:3-23 of the Administrative Code.~~
- (E) ~~For dates of service as of January 1, 2006 through June 30, 2008, the department has adopted a modified dental benefit that is less in amount, scope and duration for consumers twenty-one years of age and older as specified by service category in rules 5101:3-5-02 to 5101:3-5-11 of the Administrative Code.~~
- (F)(E) Unless otherwise specified, reimbursement for covered dental services provided by eligible providers to eligible consumers is contained in appendix DD of rule 5101:3-1-60 of the Administrative Code.
- (G)(F) Reimbursement for some services covered under the medicaid program is available only upon obtaining prior authorization from the ~~department~~ Ohio department of job and family services (ODJFS) as specified in accordance with rule 5101:3-1-31 of the Administrative Code. Dental services which require prior authorization are identified in Chapter 5101:3-5 of the Administrative Code. ~~Prior authorization requests for dental services should be submitted utilizing as appropriate forms JFS 03612 (prior authorization for dental services) or JFS 03630 (referral evaluation criteria for comprehensive orthodontic treatment), appendix to this rule.~~ A completed prior authorization request for such dental services is required for reimbursement consideration.

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

Effective: 08/02/2011

R.C. 119.032 review dates: 09/20/2010 and 08/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 06/06/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.0112

Rule Amplifies: 5111.01, 5111.0112, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 9/2/85, 2/1/88, 11/15/93, 12/29/95 (Emer.), 3/21/96, 1/1/00, 10/1/03, 1/1/06, 7/1/08

MHTL 3335-09-02

Effective Date: January 1, 2010

Most Current Prior Effective Date: July 1, 2008

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

(A) Clinical oral examination.

(1) Comprehensive oral evaluation.

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

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

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

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

(2) Periodic oral evaluation.

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

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

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

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

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

- (3) Limited oral evaluation - problem focused.
 - (a) An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures.
 - (b) The limited oral evaluation - problem focused shall include any necessary palliative treatment.
 - (c) Evaluations solely for the purpose of adjusting dentures are noncovered except as specified in rule [5101:3-28-04](#) of the Administrative Code.
 - (d) The limited oral evaluation - problem focused may not be billed in conjunction with other dental procedures, with the exception of x-rays on the same date of service.

(B) Radiographs/diagnostic imaging (including interpretation). All radiographs, when presented to the department for review, shall be of diagnostic quality, properly mounted, properly exposed, clearly focused, clearly readable and free from defect for the area of the mouth on which the radiograph was performed.

- (1) Intraoral, complete series (including bitewings).
 - (a) A complete series of radiographs shall consist of a minimum of twelve or more films. This shall include all periapical, bitewing, and occlusal film necessary for the diagnosis.
 - (b) A complete series of radiographs is allowed only once every five years. If a complete set of radiographs is required more frequently, prior authorization must be obtained.
 - (c) Periapical films shall show complete visibility of the periodontal ligament, crown and root structure in its entirety.
- (2) Intraoral periapical, first film.
- (3) Each additional intraoral periapical film.
- (4) Intraoral occlusal film.
- (5) Extraoral - first film. The extraoral film shall be allowed as an adjunct to complex treatment.
- (6) Bitewing - single film.
- (7) Bitewing - two films.
- (8) Bitewing - three films.
- (9) Bitewing - complete series, minimum of four films.
 - (a) The complete bitewing series is only reimbursable in the presence of erupted permanent second molars. Bitewing radiographs, in combination with other radiographs or when made alone, are allowed at six-month intervals providing they do not exceed the limitations set forth in paragraph (B) of this rule.
 - (b) Bitewing radiographs are permitted as frequently as at six month intervals, however, they are recommended at intervals of six to twenty four months, consistent with consumer risk for oral disease.
 - (c) Bitewing films shall show complete visibility of clinical crowns with no overlapping and cannot be substituted for periapical films in instances where endodontic treatment is necessary.
- (10) Panoramic film.
 - (a) The panoramic film is an extraoral radiograph on which the maxilla and mandible are depicted on a single film.
 - (b) All bitewing and periapical film needed to render the necessary radiographic diagnosis is included in the fee for panoramic radiographs.

- (c) Panoramic radiographs shall be permitted for consumers six years of age and older. If the dentist feels that it is medically necessary for a consumer under six years old to receive a panoramic radiograph, prior authorization must be obtained.
 - (d) Panoramic radiographs shall not be repeated more frequently than once every five years. If such radiographs are required more frequently, prior authorization must be obtained.
 - (e) Panoramic radiographs shall not occur in combination with a complete series of radiographs. A minimum of five years must elapse between the provision of panoramic radiographs and a complete series of radiographs, unless prior authorization is obtained.
 - (f) Panoramic films shall show complete visibility of tooth crowns, roots, bony and soft tissues in both arches with little or no overlapping of tooth crowns.
- (11) Cephalometric film with tracing. Prior authorization shall be required for cephalometric films and tracings.
 - (12) Diagnostic photographs in conjunction with orthodontic treatment. Prior authorization shall be required for diagnostic photographs.
 - (13) Temporomandibular joint films. Prior authorization shall be required for temporomandibular joint films including submission of consumer history and treatment plan. Temporomandibular joint films to include four to six films are covered only if required by the department. Effective for dates of service from January 1, 2006 through June 30, 2008, temporomandibular joint films were covered only for consumers twenty-years of age and younger.

Effective: 01/01/2010

R.C. 119.032 review dates: 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 12/14/2009

Promulgated Under: 119.03

Statutory Authority: 5111.0112, 5111.02, Section 309.30.75 of Am. Sub. H.B. 1, 128th G.A

Rule Amplifies: 5111.01, 5111.02, 5111.021, Section 309.30.75 of Am. Sub. H.B. 1, 128th G.A

Prior Effective Dates: 4/7/77, 12/21/77, 91/85 (Emer), 11/27/85 (Emer), 5/9/86, 2/1/88, 11/15/93, 12/29/95 (Emer), 3/21/96, 1/1/00, 10/1/03, 1/1/06, 12/29/06 (Emer), 3/29/07, 7/1/08

5160-5-03 Dental Program: Covered Tests and Laboratory Examinations and Limitations

***Formerly* 5101:3-5-03 Dental Program: Covered Tests and Laboratory Examinations and Limitations**

Effective Date: January 1, 2006

Most current prior effective date: [October 1, 2003](#)

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

- (A) Biopsy of oral tissue - hard (bone, tooth).
- (B) Biopsy of oral tissue - soft (all others).
- (C) For the medicaid program, "biopsy" is defined as the removal of tissue from the patient for microscopic examination for the purpose of diagnosis, estimation of prognosis, and treatment planning.
- (D) Diagnostic casts.
 - (1) Prior authorization shall be required for diagnostic casts. The prior authorization request for the diagnostic cast may be submitted with the completed cast when the cast is submitted for prior authorization for the proposed treatment. Prior authorization for the cast and the proposed treatment may be requested on the same prior authorization form. Providers may submit diagnostic casts in digital format or as a physical cast.
 - (2) Diagnostic casts shall be approved by the department for the evaluation of requested treatments listed throughout this chapter which state that diagnostic casts are necessary.

Effective: 01/01/2006

R.C. 119.032 review dates: 09/29/2005 and 01/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 12/14/2005

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 4/7/77, 12/21/77, 5/9/86, 2/1/88, 1/1/00, 10/01/03

Effective Date: March 28, 2013

Most Current Prior Effective Date: [December 31, 2012 \(Emergency\)](#)

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

- (A) Prophylaxis.
 - (1) Dental prophylaxis, adult.
 - (a) This shall include the necessary scaling and/or polishing procedures of the teeth to remove coronal plaque, calculus and stains of transitional or permanent dentition for consumers ages fourteen and older.
 - (b) Effective for dates of service on or after January 1, 2006, the dental prophylaxis shall not occur more frequently than once every one hundred eighty days for consumers twenty-years of age and younger. Those prophylaxes occurring more frequently than once every one hundred eighty days shall not be reimbursed by the department.
 - (c) Effective for dates of service from January 1, 2006 through June 30, 2008, the dental prophylaxis shall not occur more frequently than once every three hundred sixty-five days for consumers twenty-one years of age and older. Effective for dates of service from July 1, 2008 through December 31, 2009, the dental prophylaxis shall not occur more frequently than once every one hundred eighty days irrespective of the consumer's age. Those prophylaxes occurring more frequently than once every one hundred eighty days shall not be reimbursed by the department.
 - (d) Effective for dates of service on or after January 1, 2010, the dental prophylaxis shall not occur more frequently than once every three hundred sixty-five days for consumers twenty-one years of age and older.
 - (2) Dental prophylaxis, child.
 - (a) This shall include the necessary scaling and/or polishing procedures to remove coronal plaque, calculus and and stains of primary or transitional dentition for consumers only through age thirteen.
 - (b) The dental prophylaxis shall not occur more frequently than once every one hundred eighty days. Those prophylaxes occurring more frequently than once every one hundred eighty days shall not be reimbursed by the department.
- (B) Topical application of fluoride ~~-child~~.
 - (1) Topical fluoride treatments (includes sodium, stannous and acid phosphate fluoride foam, gel, varnish and in-office rinse) shall be allowed for consumers under the age of twenty-one.
 - (2) Treatment that incorporates fluoride with the polishing compound shall be considered part of the prophylaxis procedure and not a separate topical fluoride treatment.
 - (3) Topical application of fluoride to the prepared portion of a tooth prior to restoration, the use of self or home fluoride application procedures, and application of sodium fluoride as a desensitizing agent are not covered treatments.
 - (4) The topical application of fluoride is limited to one application per one hundred eighty days.
- (C) Sealant - per tooth. Pit and fissure sealants shall be permitted on previously unrestored occlusal areas of permanent molars subject to the following limitations:
 - (1) Sealants shall be allowed on permanent first molars for consumers under age eighteen.

- (2) Sealants shall be allowed on permanent second molars for consumers under age eighteen.
- (D) Space maintenance (passive appliances).
 - (1) Effective for dates of service from January 1, 2006 through June 30, 2008, space maintenance (passive appliances) were not covered services for consumers twenty-one years of age and older.
 - (2) Space maintainer - fixed - unilateral.
 - (3) Space maintainer - fixed - bilateral.
 - (4) Space maintainer - removable - unilateral.
 - (5) Space maintainer - removable bilateral.
 - (6) The preservation of arch length should be the main consideration in the evaluation of a consumer for a space maintainer. Space maintainers are permitted after the loss of a young permanent tooth or the premature loss of a primary tooth when an indeterminate time exists before the eruption of the permanent tooth.

Effective: 03/28/2013

R.C. 119.032 review dates: 03/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 03/18/2013

Promulgated Under: 119.03

Statutory Authority: 5111.02, Section 309.30.75 of Am. Sub. H.B. 1, 128th G.A.

Rule Amplifies: 5111.01, 5111.02, 5111.021, Section 309.30.75 of

Am. Sub. H.B. 1, 128th G.A.

Prior Effective Dates: /7/77, 12/21/77, 5/9/86, 2/1/88, 11/15/93, 1/1/00, 10/1/03, 1/1/06, 7/1/08, 12/31/08(Emer).3/31/09, 1/1/10, 12/31/12(Emer)

MHTL 3335-08-01

Effective Date: July 1, 2008

Most Current Prior Effective Date: January 1, 2006

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

- (A) Amalgam restorations (including polishing).
 - (1) Amalgam - one surface, primary or permanent.
 - (2) Amalgam - two surfaces, primary or permanent.
 - (3) Amalgam - three surfaces, primary or permanent.
 - (4) Amalgam - four or more surfaces, primary or permanent.
 - (5) Payment shall not be made for separate occlusal restorations, other than on maxillary molars. Reimbursement for occlusal surface restorations, other than on maxillary molars, includes one or more restorations on that surface.
- (B) Pin retention-exclusive of amalgam restoration per tooth, in addition to restoration. A maximum of three pins per tooth restoration shall be allowed as a covered service.
- (C) Bases and copalite or calcium hydroxide liners placed under a restoration will be considered part of the restoration and not reimbursable as separate procedures.
- (D) Local anesthesia shall be included in the fee for all restorative services.
- (E) Resin - based composite restorations - direct.
 - (1) Resin-based composite restorations - anterior.
 - (a) Resin-based composite - one surface, anterior.
 - (b) Resin-based composite - two surface, anterior.
 - (c) Resin-based composite - three surface, anterior.
 - (d) Resin-based composite - four or more surfaces or involving incisal angle (anterior).
 - (2) Resin-based composite restorations - posterior.
 - (a) Resin-based composite - one surface, posterior.
 - (b) Effective for dates of service on or after January 1, 2004, resin-based composite - two surfaces.
 - (c) Effective for dates of service on or after January 1, 2004, resin-based composite - three surfaces, posterior.
 - (d) Effective for dates of service on or after January 1, 2004, resin-based composite - four or more surfaces, posterior.
 - (3) Pin retention- per tooth, in addition to restoration (resin-based composite). A maximum of three pins per tooth shall be allowed as a covered service.
 - (4) Resin-based composite restorations shall be permitted for anterior teeth and class I or class V restorations on posterior teeth.
 - (5) Effective for dates of service on or after January 1, 2004, resin-based composite restorations shall be permitted for class II restorations on posterior teeth.
 - (6) The fee for resin-based composite restorations shall include any necessary acid etching.

- (F) Maximum reimbursement for restorations shall be limited to no more than three restorations per tooth regardless of the number of surfaces restored.
- (G) Single surface resin-based composite restorations shall involve repair to decay into the dentin.
- (H) A tooth with decay on three surfaces that can be restored with separate restorations in accordance with accepted standards of dental practice may be billed and will be reimbursed as separate restorations

~~(H)~~(I) Preventive resin restorations are not covered services.

~~(H)~~(J) Crowns.

- (1) Effective for dates of service ~~on and after~~ from January 1, 2006 through June 30, 2008, crowns, posts and related services ~~will were not no longer be~~ covered dental services for consumers twenty-one years and older.
- (2) Crown - porcelain fused to noble metal.
 - (a) Prior authorization is required for porcelain fused to noble metal crowns. A periapical radiograph of the involved tooth must be submitted with each request.
 - (b) The fee for crowns includes the temporary crown which is placed on the prepared tooth and worn while the permanent crown is being prepared.
 - (c) Porcelain with metal crowns shall be authorized only for permanent anterior teeth.
- (3) Prefabricated stainless steel crown. Stainless steel crowns shall be allowed only for teeth where multisurface restorations are needed and amalgam restorations and other materials have a poor prognosis.
 - (a) Prefabricated stainless steel crown - primary tooth
 - (b) Prefabricated stainless steel crown - permanent tooth.
- (4) Prefabricated stainless steel crown with resin window. Open face stainless steel crown with aesthetic resin facing or veneer.
 - (a) Prefabricated stainless steel crowns with resin window shall be covered for anterior teeth only.
 - (b) The fee for prefabricated stainless steel crowns with resin window includes any necessary composite restoration.
- (5) Cast post and core in addition to crown.
 - (a) Prior authorization is required for crowns with a post and core. A periapical radiograph of the involved tooth must be submitted with each request.
 - (b) Crowns with a post and core shall be approved only for endodontically treated permanent anterior teeth without sufficient tooth structure to support a crown.

Effective: 07/01/2008

R.C. 119.032 review dates: 10/16/2007 and 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 06/11/2008

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Rule Amplifies: 5111.01, 5111.02, 5111.021

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MHTL 3335-11-01

Effective Date: March 30, 2011

Most Current Prior Effective Date: December 30, 2010 (Emergency)

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

- (A) Effective for dates of service from January 1, 2006 through June 30, 2008, coverage for endodontic services for consumers twenty-one years of age and older was limited to anterior endodontic procedures.
- (B) Therapeutic pulpotomy and pulpal therapy.
 - (1) Therapeutic pulpotomy and pulpal therapy shall be covered only for consumers under the age of twenty-one.
 - (2) Therapeutic pulpotomy and pulpal therapy as separate procedures shall not occur in combination with root canal therapy.
 - (3) The restoration for the completed pulpal therapy or pulpotomy shall be billed as a separate procedure.
- (C) Endodontic therapy (complete root canal therapy).
 - (1) Anterior - tooth (excluding final restoration).
 - (2) Bicuspid - tooth (excluding final restoration).
 - (3) Molar - tooth (excluding final restoration).
 - (4) Endodontic therapy is covered only when the overall health of the dentition and periodontium is good except for the endodontically indicated tooth/teeth. Decay must be above the bone level. Radiographs, including periapical, must be clearly readable and show periapical radiolucency or widening of periodontal ligament and be accompanied with chronic pain (as evidenced by sensitivity to hot or cold, percussion or palpation) or presence of fistula associated with tooth or chronic infection. If pathology is not visible on radiograph, endodontic treatment must be evidenced by clinical documentation.
 - (5) Endodontic therapy is covered only for permanent teeth.
 - (6) All diagnostic tests, evaluations, radiographs, and postoperative treatment are included in the fee.
- (D) Apicoectomy/periradicular services.
 - (1) Apicoectomy/periradicular services shall be a covered service on permanent teeth only.
 - (2) Prior authorization is required for apicoectomy/periradicular services. All available radiographs of the mouth, properly mounted and clearly readable, must be submitted with each request. A periapical view of the tooth and the periapical area involved must be included.
- (E) Apexification/recalcification procedures.
 - (1) Apical closure.
 - (a) Apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
 - (i) Apexification/recalcification includes opening tooth, ~~pulpectomy~~, preparation of canal spaces, first placement of medication and necessary radiographs.

- (ii) This procedure ~~is~~ may include the first phase of endodontic (complete root canal) therapy.
- (b) Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
This procedure is for visits in which the intra-canal medication is replaced with new medication and necessary radiographs.
- (c) Apexification/recalcification - final visit (includes completed endodontic therapy - apical closure/calcific repair of perforations, root resorption, etc.)
 - (i) This procedure includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs.
 - (ii) This procedure includes last phase of endodontic (complete root canal) therapy.
- (2) Apical closure does not include endodontic (root canal) therapy.
- (3) Prior authorization is required for each apexification/recalcification procedure.

Effective: 03/30/2011

R.C. 119.032 review dates: 01/07/2011 and 03/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 03/17/2011

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Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

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5160-5-07 Dental Program: Covered Periodontic Services and Limitations

Formerly 5101:3-5-07 Dental Program: Covered Periodontic Services and Limitations

MHTL 3335-09-01

Effective Date: March 31, 2009

Most Current Prior Effective Date: December 31, 2008

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

- (A) Effective for dates of service from January 1, 2006 through June 30, 2008, periododontic services were not covered services for consumers twenty-one years of age and older.
- (B) Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant. Prior authorization is required for gingivectomy and gingivoplasty services. Complete radiographs of the mouth and diagnostic casts must be submitted with each request.
- (C) Gingivectomy or gingivoplasty surgery is not usually covered under the medicaid program. One exception to program coverage limitations is to correct severe hyperplasia or hypertrophic gingivitis associated with drug therapy or hormonal disturbances.

Effective: 03/31/2009

R.C. 119.032 review dates: 01/13/2009 and 03/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 03/20/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 1/2/00, 10/1/03, 1/1/06, 7/1/08, 12/31/08 (Emer)

MHTL 3335-08-01

Effective Date: July 1, 2008

Most Current Prior Effective Date: January 1, 2006

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

- (A) Complete dentures (including routine post-delivery care).
- (1) Complete denture - maxillary.
 - (2) Complete denture - mandibular.
 - (3) All dentures must be prior authorized. In cases where the recipient is not edentulous prior to requesting dentures, complete radiographs of the mouth, properly mounted and clearly readable, must be submitted with each denture request. Radiographs must be taken prior to extractions. Radiographs are not necessary for those individuals edentulous prior to requesting dentures.
 - (4) The diagnosis for dentures shall be based on the total condition of the mouth, ability to adjust to dentures, and the desire to wear dentures. Natural teeth that have healthy bone, are sound, and do not have to be extracted must not be removed.
 - (5) Complete extractions must be deferred until authorization to construct the denture has been given, except in absolute emergency situations.
 - (6) The dental care program shall not authorize immediate dentures except in very unusual circumstances which must be documented and approved by the department.
 - (7) A denture, complete, partial, or combination thereof, shall not be replaced or remade within eight years except for very unusual circumstances.
 - (8) The dentist shall be responsible for constructing a complete functional denture. The fee for dentures includes all necessary corrections and adjustments for a period of six months after seating the denture.
 - (9) A preformed denture with teeth already mounted (that is, teeth already set in acrylic prior to initial impressions), forming a denture module, is not a covered service.
 - (10) A denture shall not be authorized when dental history reveals that any or all dentures made in recent years have been unsatisfactory for reasons that are not remediable because of psychological or physiological reasons.
- (B) Partial dentures.
- (1) Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
 - (2) Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).
 - ~~(3) Each additional clasp with rest. This procedure shall be authorized for cast base partials only.~~
 - ~~(4)~~(3) Maxillary partial denture - resin base (including conventional clasps, rests and teeth). This procedure includes acrylic resin base denture with resin or wrought wire clasps. This procedure is a covered service for patients age eighteen and younger.
 - ~~(5)~~(4) Mandibular partial denture-resin base (including any conventional clasps, rests and teeth). This procedure includes acrylic resin base denture with resin or wrought wire clasps. This procedure is a covered service for patients age eighteen and younger.

- ~~(6)~~(5) All partial dentures must be prior-authorized. Complete radiographs of the mouth, properly mounted and clearly readable, must be submitted with each request.
- ~~(7)~~ ~~The maximum number of clasps permitted for payment for any partial denture is four.~~
- ~~(8)~~(6) Partial dentures cannot be replaced, remade, or exchanged for complete dentures for a minimum period of eight years except for unusual situations when justification for the new dentures can be established.
- ~~(9)~~(7) Partial dentures are authorized when several teeth are missing in the arch and the masticatory function is severely impaired or when anterior teeth are missing in the arch which will affect the appearance of the patient.
- ~~(10)~~(8) The dentist shall be responsible for constructing a complete functional partial denture. The fee for a partial denture includes all necessary corrections and adjustments for a period of six months after seating the partial denture.

(C) Repairs to dentures.

- (1) Repairs to complete dentures.
 - (a) Repair broken complete denture base.
 - (b) Replace missing or broken teeth - complete denture (each tooth).
- (2) Repairs to partial dentures.
 - (a) Repair resin denture base.
 - (b) Repair cast framework.
 - (c) Repair or replace broken clasp.
 - (d) Replace broken teeth - per tooth.
 - (e) Add tooth to existing partial denture.
 - (f) Add clasp to existing partial denture.

(D) Denture relining procedures.

- (1) Reline complete maxillary denture.
- (2) Reline complete mandibular denture.
- (3) Reline partial maxillary denture.
- (4) Reline partial mandibular denture.
- (5) The relining must consist of the readaptation of the denture to the present oral tissues using accepted dental practice standards and procedures. The denture must be processed and finished with materials chemically compatible with the existing denture base. Chairside self-curing materials are not allowed.
- (6) A complete or partial denture relining shall not occur more frequently than once every four years and not before four years after construction of the complete or partial denture except for unusual circumstances which must be documented.
- (7) All complete and partial denture relining procedures include six months of post-delivery care.

Effective: 07/01/2008

R.C. 119.032 review dates: 10/16/2007 and 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

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MHTL 3335-11-01

Effective Date: March 30, 2011

Most Current Prior Effective Date: December 30, 2010 (Emergency)

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

- (A) Effective for dates of service from January 1, 2006 through June 30, 2008, coverage of oral surgery services for consumers twenty-one years of age and older were limited to extractions (extraction, erupted tooth, or exposed root), surgical excision and incision and surgical procedures covered as physician services utilizing current procedural terminology (CPT) codes.
- (B) The decision to remove a tooth or teeth must be based on the tooth or teeth being too broken down to save, too poorly supported by alveolar bone to save, and/or the presence of some pathological condition which contraindicates saving. Extractions that render a consumer edentulous must be deferred until authorization to construct a denture has been given, except in absolute emergency situations.
- (C) The extraction of an impacted tooth is authorized only when conditions arising from such an impaction warrant its removal. The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is symptomatic.
- (D) Local anesthesia and routine postoperative care are included in the fee for extractions.
- (E) Extractions (includes local anesthesia, suturing, if needed and routine postoperative care).
 - (1) Extraction, erupted tooth or exposed root (elevation and/or forceps removal).
 - (2) Extraction, erupted tooth or exposed root (elevation and/or forceps removal) may be billed only once per tooth.
- (F) Surgical extraction.
 - (1) Removal of impacted tooth - soft tissue. A "soft tissue impaction" is any tooth which requires an incision of overlying soft tissue and removal of the tooth without necessity of removing the bone. Partial eruption of a tooth with portions of the crown located at or above the occlusal plane does not disqualify the tooth as a soft tissue impaction if the position is such that soft tissue does in fact cover portions of the occlusal surface, for example, distoangular position. This procedure shall be permitted for third molars only without prior authorization. All other procedures shall require prior authorization.
 - (2) Removal of impacted tooth - partially bony. A "partially bony impaction" is one where the crown of the tooth is partially covered by bone. This tooth may or may not be partially erupted. This type of impaction requires an incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth. Partial eruption of a tooth with portions of the crown located at or above the occlusal plane does not disqualify this tooth from being classified a partially bony impaction if bone does in fact cover the greatest convexity of the distal portion of the crown, for example, distoangular position within the ramus of the mandible. If not visible on radiograph, bony impaction must be evidenced from clinical documentation. A radiograph of the impaction must be maintained in the patient's clinical record.
 - (3) Removal of impacted tooth - completely bony. A "completely bony impaction" is one where the crown of the tooth is completely covered by bone or a substantial part of the tooth above the greatest convexity of the crown is covered by bone on both the mesial and distal sides as demonstrated radiographically. In the case of horizontally impacted lower third molars, to be classified as a completely bony impaction the central groove of the crown must not be located superior to the occlusal plane. This type impaction requires an incision of overlying soft tissue,

elevation of a flap, removal of bone, and sectioning of the tooth, if necessary for removal. Prior authorization is required for all completely bony impactions including a radiograph of the impaction.

- (4) Removal of impacted tooth - completely bony with unusual surgical complications. Prior authorization is required for all completely bony impactions including a radiograph of the impaction.
 - (5) Surgical removal of a residual tooth roots (cutting procedure). Prior authorization is required for this procedure.
 - (6) Surgical removal of a supernumerary tooth. Prior authorization is required for the surgical removal of a supernumerary tooth. Surgical removal of supernumerary teeth must be billed on a paper claim form using local level program code Y7255 until a CDT code is assigned for this procedure.
- (G) Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus. This procedure shall be authorized by report. Submission of radiographs of the area and a detailed explanation of the findings and treatment are required for authorization.
- (H) Alveoplasty - surgical preparation of ridges for dentures.
- (1) Alveoplasty is a covered service only when provided in conjunction with the construction of a prosthodontic appliance.
 - (2) Alveoplasty in conjunction with extractions - per quadrant.
 - (3) Alveoplasty, not in conjunction with extractions - per quadrant.
- (I) Surgical excision.
- (1) Coverage of removal of cysts or tumors is on a by-report basis. Submission of radiographs of the area and detailed explanation of findings and treatment are required for authorization.
 - (2) Removal of benign odontogenic cyst or tumor- lesion diameter up to 1.25 cm.
 - (3) Removal of benign odontogenic cyst or tumor- lesion diameter greater than 1.25 cm.
 - (4) Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
 - (5) Removal of benign nonodontogenic cyst or tumor- lesion diameter greater than 1.25 cm.
 - (6) Removal of lateral exostosis (maxilla or mandible).
 - (a) Prior authorization is required for all removal of lateral exostosis procedures.
 - (b) A study cast of the mouth with the area of surgery outlined must be submitted for prior authorization.
- (J) Surgical incision.
- (1) Incision and drainage of abscess - intraoral soft tissue.
 - (2) Incision and drainage of abscess - extraoral soft tissue.
 - (3) Coverage of incision and drainage of abscesses is on a by-report basis requiring submission of radiographs of the area and detailed explanation of findings and treatment.
- (K) Treatment of fractures.
- (1) The treatment of fractures should be billed to the department using codes from the "American Medical Association's Current Procedural Terminology (CPT)".
 - (2) Alveolus - open reduction, may include stabilization of teeth, may be billed as a CPT code or dental code.
- (L) Other repair procedures.

- (1) Frenulectomy - also known as ~~{frenectomy or frenotomy}~~ - separate procedure not incidental to another procedure. Prior authorization is required and must include submission of complete radiographs of the mouth and study casts of the arch with outline of indicated surgery .
 - (2) Excision of hyperplastic tissue - per arch. Prior authorization is required and must include submission of complete radiographs of the mouth and study casts of the arch with the outline of the indicated surgery.
- (M) Oral surgery services shall be billed to the department using procedure codes from either the surgery section, CPT codes or dental codes as defined in rule [5101:3-1-19.3](#) of the Administrative Code. Regardless of the code used, all claims must be submitted to the department on the appropriate claim type.

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(Emer)

[MHTL 3335-11-02](#)

Effective Date: August 2, 2011

Most Current Prior Effective Date: [July 1, 2008](#)

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

- (A) Surgical access of an unerupted tooth. Coverage is limited to situations whereby an orthodontic attachment is placed on the crown to facilitate eruption. Prior authorization is required. Complete radiographs must be submitted with each request.
- (B) Minor treatments to control harmful habits.
 - (1) Fixed appliance therapy.
 - (2) Removable appliance therapy.
 - (3) Prior authorization is required on all tooth guidance appliances to control harmful habits including, but not limited to, thumb- and finger-sucking, tongue-thrusting, and bruxism. Complete radiographs and study models of the mouth must be submitted with each request.
 - ~~(4) Effective for dates of service from January 1, 2006 through June 30, 2008, minor treatments to control harmful habits were not covered dental services for consumers twenty-one years of age and older.~~
- (C) Comprehensive orthodontics.
 - (1) Coverage of comprehensive orthodontics is limited to the most severe handicapping orthodontic conditions. Coverage is further limited to consumers under age twenty-one. Only one course of orthodontic treatment per consumer, per lifetime is covered.
 - (2) Prior authorization is required for all comprehensive orthodontic treatment. ~~The following must be included with the prior authorization request.~~ Effective December 7, 2010, all prior authorization requests must be submitted through the Ohio department of job and family services (ODJFS) web portal. Paper prior authorization requests will be returned to the provider unprocessed.
Documentation necessary to complete the prior authorization request that cannot be uploaded and submitted through the ODJFS web portal, such as x-rays and dental molds, must be submitted separately.
The following must be included with the prior authorization request:
 - (a) A completed prior authorization request. ~~form (JFS 03612/appendix to rule 5101:3-5-01 of the Administrative Code).~~
 - (b) Lateral and frontal photographs of consumer with lips together.
 - (c) Cephalometric film with lips together, including a tracing.
 - (d) A complete series of radiographs or a panoramic radiograph.
 - (e) Diagnostic models.
 - (f) Treatment plan, including projected length and cost of treatment.
 - (g) A completed referral evaluation criteria form (JFS 03630/appendix to rule 5101:3-5-01 of the Administrative Code). A consumer must demonstrate a minimum of five symptoms, with at least two of the symptoms appearing under dentofacial abnormality before the provider submits a request for consideration.

- (3) Upon evaluation of all the documentation which includes study models, cephalometric film and tracing, radiographs, photographs, and the referral evaluation criteria form, the department will determine if the condition will be considered a severely handicapping orthodontic condition and covered by medicaid. If the case is denied, the prior authorization will be returned to the provider indicating that the orthodontic treatment will not be reimbursed by Ohio medicaid. However, an authorization will be issued for the payment of the photographs, cephalometric radiograph and tracing, and the diagnostic models. Full mouth radiographs and panoramic films do not require prior authorization and can be billed separately on a dental invoice by the dentist who provided the radiographs.
- (4) The original prior authorization will cover the entire course of treatment as long as the consumer remains eligible for medicaid services. For those cases approved for treatment, the department will issue a prior authorization that approves payment for the records and the first quarter of treatment. Payment for subsequent quarters of orthodontic treatment will be made at the beginning of each quarter of active treatment through a maximum of eight quarters. Also, payment will be made for retention services after the active treatment is completed. The dentist, using the original prior authorization number, should bill the department every ninety days at the beginning of the quarter to receive payment for that quarter. At the end of the active treatment, the department can be billed one time per arch for retention service. Payment will not be made for active treatment after retention is begun.
- (5) If the consumer becomes ineligible during the time that comprehensive orthodontic treatment is being rendered, the quarter payment will permit coverage to continue through the end of the authorized quarter of treatment. For example, if the prior authorized treatment quarter begins February first, and the consumer becomes ineligible as of March first, treatment is to continue through the remainder of the quarter for which payment has been made, (February first - April thirtieth). It will be the responsibility of the consumer and the dentist to determine a payment mechanism for subsequent quarters of treatment provided when the consumer is ineligible for medicaid.
- (6) Payment for active treatment will be made for a maximum of eight quarters. In some cases more ~~that~~ than eight quarters may be necessary to complete treatment. However, the fee associated with eight quarters of treatment is the maximum amount reimbursable and is considered payment-in-full. No additional reimbursement can be sought from the department, consumer, or other source if the treatment requires additional quarters.

Effective: 08/02/2011

R.C. 119.032 review dates: 09/20/2010 and 08/01/2016

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MHTL 3335-08-01

Effective Date: July 1, 2008

Most Current Prior Effective Date: January 1, 2006

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

- (A) Anesthesia for dental procedures.
- (1) "General anesthesia" is defined as a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, inability to independently maintain an airway, inability to respond purposefully to physical stimulation or verbal command with resultant amnesia related to the surgical procedure.
 - (2) General anesthesia shall be reimbursed at a flat rate per ~~patient~~ consumer per date of service. A twenty-five dollar in-office incentive payment shall be added to the reimbursement for general anesthesia provided in an office setting.
 - (3) The administration of general anesthesia will be covered for surgical and restorative procedures when performed by an eligible provider as defined in rule 5101:3-5-01 of the Administrative Code. The cost of analgesic and local anesthetic agents is included in the fees associated with dental services reimbursed by the medicaid program.
- (B) Dental services performed in long-term care facilities or private homes.
- (1) Dental services rendered to ~~patients~~ consumers in long-term care facilities or private homes are covered in accordance with the coverage and limitations set forth in Chapter 5101:3-5 of the Administrative Code.
 - (2) An updated medical and dental history, diagnosis, prognosis, and treatment plan must be maintained in the provider's office. For ~~patients~~ consumers residing in long-term care facilities, a copy of this record must also be maintained in the facility.
 - (3) A record of the request for treatment, signed by the ~~individual~~ consumer, family member, responsible guardian, or attending physician, must be maintained in the ~~patient's~~ consumer's permanent record at the long-term care facility and the provider's office.
 - (4) When requesting services that require prior authorization (PA), a copy of the request for treatment must be submitted with the PA request along with any study casts or radiographs that may be required. Additionally, when the PA request is for dentures or partials, a copy of the most recent nursing care plan must be submitted to the department with the request.
- (C) Inpatient hospital services.
- All elective inpatient hospital admissions require preadmission certification in accordance with ~~rules~~ rule 5101:3-2-40 ~~to 5101:3-2-42~~ of the Administrative Code.
- (D) Therapeutic drug injection, by report. This procedure shall be authorized by report.
- (E) Temporomandibular therapy.
- (1) Effective for dates of service ~~on or after~~ from January 1, 2006 through June 30, 2008, temporomandibular therapy services ~~will no longer be~~ were not covered services for consumers twenty-one years of age and older.
 - (2) All treatment for temporomandibular joint therapy requires prior authorization.
 - (3) Panoramic radiographs, diagnostic casts, and a report of the clinical findings and symptoms must be submitted with each request for prior authorization.
 - (4) The fee allowed for the temporomandibular therapy includes six months of adjustments.

- (F) Maxillofacial prosthetics. Prior authorization is required and must include a detailed treatment plan, full mouth radiographs, and hospital operative report, if applicable.
- (G) Miscellaneous services. Unspecified adjunctive procedure, by report.
 - (1) Unusual and/or specialized treatment required to safeguard the health and welfare of the ~~patient~~ consumer.
 - (2) Prior authorization is required and must include detailed information on the difficulty and complications of the service and complete radiographs of the ~~mouth~~ mouth, if indicated. An estimation of the usual fee charged for the service must also be submitted with the prior authorization request.

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Billing Instructions

Click [here](#) to view the Billing instructions eManual.

Notice

A Dental Services provider handbook is currently not available.

Below please find Medicaid Handbook Transmittal Letters (MHTLs), Medical Assistance Letters (MALs) and Ohio Administrative Code (OAC) rules regarding Dental Services and links to the OAC (found in the Legal Services collection).