

Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's [Proposed Changes Blog](#).

OHCA COMMENT DUE DATE: September 2, 2021

The proposed policy is an Emergency Rule. The proposed policy was presented at the June 8, 2021 Tribal Consultation. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on September 9, 2021 and the OHCA Board of Directors on September 20, 2021.

Reference: APA WF # 21-17

SUMMARY:

Adult Dental Limited Benefit Revisions – The proposed revisions will update the current adult dental policy to outline new benefits for SoonerCare adults.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; Oklahoma Senate Bill 1046

RULE IMPACT STATEMENT:

**STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY**

SUBJECT: Rule Impact Statement
APA WF # 21-17

A. Brief description of the purpose of the rule:

The proposed revisions will comply with Oklahoma Senate Bill 1046, which directed the Oklahoma Health Care Authority to expand its adult dental benefit. The revisions will add dental examinations, x-rays, dental cleanings, fluoride, dental fillings, scaling and root planing, as well as dentures and partial dentures as covered services for SoonerCare adult members. The proposed revisions will delineate coverage as well as any applicable service limitation(s). Furthermore, the revisions will state that the new adult dental services will be reimbursed pursuant to the current established reimbursement methodology within the Oklahoma State Plan. Finally, revisions

will involve minor cleanup to fix grammatical and formatting errors.

- B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

SoonerCare adult members who utilize dental services will be positively affected by the proposed rule changes.

Dental providers will also be affected by the proposed rule changes.

- C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes to expand coverage for SoonerCare adult dental services will benefit SoonerCare adult members by allowing access to certain benefits that were not previously provided.

Additionally, the proposed rule changes will benefit dental providers by allowing reimbursement for the delivery of expanded dental services to SoonerCare adult members.

- D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact, and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

- E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The estimated budget impact, for SFY2022, will be an increase in the total amount of \$68,653,438; with \$14,124,398 state share. The estimated budget impact, for SFY2023, will be an

increase in the total amount of \$68,653,438; with \$14,867,564 state share.

- F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule changes will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule changes.

- G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule is not expected to have an adverse effect on small business.

- H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The Agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

- I. A determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule should have no adverse effect on the public health, safety, and environment.

- J. A determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented:

The Agency anticipates that in the absence of these rule changes it will hinder SoonerCare adult members from receiving needed dental services. Additionally, it would place the Agency out of compliance with Oklahoma Senate Bill 1046.

- K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: July 23, 2021

RULE TEXT:

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.** The OHCA Dental Program provides basic medically necessary treatment. The services listed below are compensable for members twenty-one (21) years of age and over without prior authorization.

(A) ~~Dental coverage for adults is limited to:~~**Comprehensive oral evaluation.** The comprehensive oral evaluation may be performed when a member has not been seen by the same dentist for more than thirty-six (36) months. The comprehensive oral evaluation should precede any images, and chart documentation must include image interpretations, caries risk assessment, six-point periodontal charting, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member once every six (6) months. An examination should precede any images, and chart documentation must include image interpretations, caries risk assessment, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images, and chart documentation must include member history, prior images, the six-point periodontal charting, and both dental and general health needs of the member. Images must be properly labeled with date and member name, and must be of diagnostic quality. Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films and two (2) bitewings are considered full

mouth images. Full mouth images as noted above or traditional [minimum of twelve (12) periapical films and two (2) posterior bitewings] are allowable once in a three (3) year period and must be of diagnostic quality. Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of Panoramic film exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental prophylaxis.** Dental prophylaxis is provided once every one hundred eighty-four (184) days along with topical application of fluoride.

(F) **Smoking and tobacco use cessation counseling.** Smoking and tobacco use cessation counseling is covered per Oklahoma Administrative Code (OAC) 317:30-5-2 (DD) (i) through (iv).

(G) **Medically necessary extractions.** Medically necessary extractions, as defined in OAC 317:30-5-695. Tooth extraction must have medical need documented.

(H) **Medical and surgical services.** Medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(I) **Additional services.** Additional covered services, which require a prior authorization, are outlined in OAC 317:30-5-698.

~~(i) Medically necessary extractions, as defined in Oklahoma Administrative Code (OAC) 317:30-5-695. Tooth extraction must have medical need documented;~~

~~(ii) Limited oral examinations and medically necessary images, as defined in OAC 317:30-5-695, associated with the extraction or with a clinical presentation with reasonable expectation that an extraction will be needed;~~

~~(iii) Smoking and tobacco use cessation counseling; and~~

~~(iv) Medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.~~

~~(B) Payment is made for dental care for adults residing in private intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age twenty-one (21).~~

~~(C) Limited dental services are available for members who~~

~~meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior authorization before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved American Dental Association (ADA) form and must include diagnostic images, six-point periodontal charting, narratives and comprehensive treatment plans. The Oklahoma Health Care Authority (OHCA) will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:~~

- ~~(i) Comprehensive oral evaluation;~~
- ~~(ii) Two (2) bitewing images;~~
- ~~(iii) Prophylaxis;~~
- ~~(iv) Fluoride application;~~
- ~~(v) Limited restorative procedures; and~~
- ~~(vi) Periodontal scaling/root planing.~~

~~(2) **Home and community-based services (HCBS) waiver for the intellectually disabled.** All providers participating in the HCBS must have a separate contract with the OHCA to provide services under the HCBS. Dental services are defined in each waiver and must be prior authorized.~~

~~(3)(2) **Children.** The OHCA Dental Program for children provides the basic medically necessary treatment. For services rendered to a minor, the minor's parent or legal guardian must provide a signed, written consent prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. The services listed below are compensable for members under twenty-one (21) years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults per OAC 317:30-5-696.1. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.~~

~~(A) **Comprehensive oral evaluation.** This procedure should precede any images, and chart documentation must include image interpretations, caries risk assessment, six-point periodontal charting (as applicable), and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure. A comprehensive oral evaluation may be performed when a member has not been seen by the same dentist for more than thirty-six (36) months. The comprehensive oral evaluation should precede any images, and chart documentation must include image interpretations, caries risk assessment, six-point~~

periodontal charting, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member ~~of record~~ once every six (6) months. An examination should precede any images, and chart documentation must include image interpretations, caries risk assessment, and both medical and dental health history of member. The comprehensive treatment plan should be the final result of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two (2) visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images, and chart documentation must include member history, prior images, caries risk assessment, the six-point periodontal charting (as applicable), and both dental and general health needs of the member. ~~The referring dentist is responsible for providing properly identified images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral.~~ Images must be properly labeled with date and member name, and must be of diagnostic quality. Periapical images must include at least three (3) millimeters beyond the apex of the tooth being imaged. Panoramic films and two (2) bitewings are considered full mouth images. Full mouth images as noted above or traditional [minimum of twelve (12) periapical films and two (2) posterior bitewings] are allowable once in a three (3) year period and must be of diagnostic quality. Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three (3) years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through eighteen (18) years of age and is compensable once every thirty-six (36) months if medical necessity is documented.

(F) **Interim caries arresting medicament application.** This service is available for primary and permanent teeth once every one hundred eighty-four (184) days for two (2) occurrences per tooth in a lifetime. The following criteria must be met for reimbursement:

- (i) A member is documented to be unable to receive restorative services in the typical office environment within a reasonable amount of time;
- (ii) A tooth that has been treated should not have any non-carious structure removed;
- (iii) A tooth that has been treated should not receive any other definitive restorative care for three (3) months following an application;
- (iv) Reimbursement for extraction of a tooth that has been treated will not be allowed for three (3) months following an application; and
- (v) The specific teeth treated and number and location of lesions must be documented.

(G) **Dental prophylaxis.** This procedure is provided once every one hundred eighty-four (184) days along with topical application of fluoride.

(H) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

- (i) Stainless steel crowns are allowed if:
 - (I) The child is five (5) years of age or under;
 - (II) Seventy percent (70%) or more of the root structure remains; or
 - (III) The procedure is provided more than twelve (12) months prior to normal exfoliation.
- (ii) Stainless steel crowns are treatment of choice for:
 - (I) Primary teeth treated with pulpal therapy, if the above conditions exist;
 - (II) Primary teeth where three (3) surfaces of extensive decay exist; or
 - (III) Primary teeth where cuspal occlusion is lost due to decay or accident.
- (iii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.
- (iv) Placement of a stainless steel crown is allowed once for a minimum period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(I) **Stainless steel crowns for permanent teeth.** The use of any stainless steel crowns is allowed as follows:

- (i) Stainless steel crowns are the treatment of choice

for:

(I) Posterior permanent teeth that have completed endodontic therapy if three (3) or more surfaces of tooth is destroyed;

(II) Posterior permanent teeth that have three (3) or more surfaces of extensive decay; or

(III) Where cuspal occlusion is lost due to decay prior to age sixteen (16) years.

(ii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of twenty-four (24) months. No other restoration on that tooth is compensable during that period of time.

(J) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre-and post-operative periapical images must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:

(I) Primary molars having at least seventy percent (70%) or more of their root structure remaining or more than twelve (12) months prior to normal exfoliation;

(II) Tooth numbers O and P before age five (5) years;

(III) Tooth numbers E and F before six (6) years;

(IV) Tooth numbers N and Q before five (5) years;

(V) Tooth numbers D and G before five (5) years.

(ii) Therapeutic pulpotomies and pulpal debridement are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one (1) year or if seventy percent (70%) or more of root structure is remaining.

(K) **Endodontics.** Payment is made for the services provided in accordance with the following:

(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior and/or any posterior root canals.

(iv) Pre and post-operative periapical images must be available for review.

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

(vi) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for twenty-four (24) month post completion.

(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six (6) months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than five (5) millimeters below the crest of the alveolar ridge.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post-operative bitewing images must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four (4) mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Pre and post-operative images must be available.

(M) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four (4) occurrences per year and is not separately reimbursable, if provided on the same date as

IV sedation, non-intravenous conscious sedation, or general anesthesia. The medical need for this service must be documented in the member's record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date ~~by the same provider~~ as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation, or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and/or the dentist, it must be medically necessary.

(N) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or mineral trioxide aggregate (MTA) materials, not a cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(O) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after sixty (60) days unless the tooth becomes symptomatic and requires pain relieving treatment.

(P) **Smoking and tobacco use cessation counseling.** ~~Smoking and tobacco use cessation counseling is covered when performed utilizing the five (5) intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight (8) sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, Oklahoma State Health Department (OSDH) and Federally Qualified Health Center (FQHC) nurses, and maternal/child health licensed clinical social workers with a Tobacco Treatment Specialist Certification (TTS-C). Chart documentation must include a separate note that addresses the 5A's, separate signature, and the member specific information addressed in the five (5) steps and the time spent by the practitioner performing the counseling.~~

~~Anything under three (3) minutes is considered part of a routine visit. Smoking and tobacco use cessation counseling is covered per OAC 317:30-5-2 (DD) (i) through (iv).~~

(Q) Diagnostic Electronic images of diagnostic casts and/or oral/facial images. ~~Diagnostic~~ Electronic images of casts and/or oral/facial images may be requested by OHCA or representatives of OHCA. ~~If cast and/or images are received they will be considered supporting documentation and may be used to make a determination for authorization of services. Submitted documentation used to base a decision will not be returned.~~ Providers will be reimbursed for either the study model or images.

(i) Documentation of casts and/or photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic ~~or paper~~ claim.

~~(ii) Oral/facial photographic images are allowed under the following conditions:~~

~~(I) When radiographic images do not adequately support the necessity for requested treatment.~~

~~(II) When photo images better support medical necessity for the requested treatment rather than diagnostic models.~~

~~(III) If a comprehensive orthodontic workup has not been performed.~~

~~(iii) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.~~

~~(I) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.~~

~~(II) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.~~

~~(iv)~~ (ii) Study models 3-D model images or photographic images not in compliance with the above described diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

(R) Additional services. Additional covered services, which require a prior authorization, are outlined in OAC 317:30-5-698.

(3) 1915(c) home and community-based services (HCBS) waivers for the intellectually disabled. Dental services are defined in each waiver and must be prior authorized.

317:30-5-698. Services requiring prior authorization

(a) **Prior authorizations.** Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis [See Oklahoma Administrative Code (OAC) 317:30-5-695(d)(2)]. Requests for dental services requiring prior authorization must be accompanied by sufficient documentation.

(b) **Requests for prior authorization.** Requests for prior authorization are filed on the currently approved American Dental Association (ADA) form. Prior authorized services must be billed exactly as they appear on the prior authorization. Payment is not made for any services provided prior to receiving authorization except for the relief of pain.

(c) **Prosthodontic services.** Prosthodontic services provided to members who have become ineligible mid-treatment are covered if the member was eligible for SoonerCare on the date the final impressions were made.

(d) **Adults.** Listed below are examples of services requiring prior authorization for members twenty-one (21) years of age and over/older. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. The images, digital media, and photographs must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) Removable prosthetics.

(A) This includes full dentures, cast frame partial dentures, and acrylic partial dentures.

(i) One (1) per every five (5) years is available for adults up to twenty-five (25) years of age.

(ii) One (1) per every seven (7) years is available for adults twenty-five (25) years of age and over.

(iii) Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(B) Partial dentures are allowed for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch. Provider must indicate which teeth will be replaced.

(2) **Periodontal scaling and root planing.** Procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. This procedure requires that each tooth involved have one (1) or more of the six-point measurements (probing pocket depths) equivalent to five (5) millimeters or greater, and image supported alveolar bone loss. Subgingival calculus and inflammation must be demonstrated for consideration of scaling and root planing. A minimum of two (2) teeth per quadrant must be involved, with the appropriate CDT code usage for fewer than four (4) teeth per quadrant. This procedure is not allowed in conjunction with any other periodontal surgery. Four quadrants of scaling and root planing are not allowed with oral prophylaxis.

(3) **Scaling in the presence of generalized moderate or severe gingival inflammation.** Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (alveolar bone loss). Generalized supra- and sub-gingival calculus, and moderate to severe inflammation must be demonstrated, with probing pocket depths of and five (5) mm or greater. This procedure is intended for scaling of the entire mouth in lieu of oral prophylaxis, and is only performed after a comprehensive evaluation has been completed.

(d)-(e) **Children.** Listed below are examples of services requiring prior authorization for members under twenty-one (21) and eligible intermediate care facilities for individuals with intellectual disabilities (ICF/IID) residents. Minimum required records to be submitted with each request are right and left mounted bitewings and periapical films or images of tooth/teeth involved or the edentulous areas if not visible in the bitewings. Images must be of diagnostic quality. Images must be identified by the tooth number and include date of exposure, member name, member ID, provider name, and provider ID. All images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination, and a completed current ADA form requesting all treatments requiring prior authorization. ~~The images, digital media, photographs, or printouts must be of sufficient quality to clearly demonstrate for the reviewer, the pathology which is the basis for the authorization request.~~The images, digital media, and photographs must be of sufficient quality to clearly demonstrate for the reviewer, the pathology

which is the basis for the authorization request. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Root canal therapy is not considered an emergency procedure unless due to trauma to an anterior tooth. The provider must document the member's oral hygiene and flossing ability in the member's records. Pulpal debridement may be performed for the relief of pain while waiting for the decision from the Oklahoma Health Care Authority (OHCA) on request for endodontics.

(A) **Anterior endodontics.** Prior authorization is required for members who have a treatment plan requiring more than two (2) anterior root canals. All rampant, active caries should be removed prior to requesting anterior endodontics. Payment is made for services provided in accordance with the following:

- (i) Permanent teeth only;
- (ii) Accepted ADA materials must be used;
- (iii) Pre and post-operative periapical images must be available for review;
- (iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion;
- (v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if crown to root ratio is poor; and
- (vi) An endodontic procedure may not be approved if the tooth requires a post and core to retain a crown.

(B) **Posterior endodontics.** The guidelines for this procedure are as follows:

- (i) The provider must document the member's oral hygiene and flossing ability in the member's records.
- (ii) Teeth that require pre-fabricated post and cores to retain a restoration due to lack of natural tooth structure may not be approved for root canal therapy.
- (iii) Pre and post-operative periapical images must be available for review.
- (iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within twenty-four (24) months post completion.
- (v) A tooth will not be approved if it appears there is not adequate natural tooth structure remaining to establish good tooth/restorative margins or if there is a poor crown to root ratio or weakened root furcation area. Approval of second molars is contingent upon proof of medical necessity.

(vi) Only ADA accepted materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure may not be approved if the tooth requires a post and core in order to present adequate structure to retain a crown.

(viii) Endodontics will not be considered if:

(I) An opposing tooth has super erupted;

(II) Loss of tooth space is one third or greater;

(III) Opposing second molars are involved unless prior authorized;

(IV) The member has multiple teeth failing due to previous inadequate root canal therapy or follow-up;
or

(V) All rampant, active caries must be removed prior to requesting posterior endodontics.

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. Core build-up code is only available for use if other restorative codes are not sufficient. These teeth will not be approved for a crown if it appears the apex is not adequately sealed.

(2) **Crowns for permanent teeth.** Crowns are compensable for restoration of natural teeth for members who are sixteen (16) years of age or older and adults residing in private ICF/IID and who have been approved for ICF/IID level of care. Certain criteria and limitations apply.

(A) The following conditions must exist for approval of this procedure:

(i) All rampant, active caries must be removed prior to requesting any type of crown;

(ii) The tooth must be decayed to such an extent to prevent proper cuspal or incisal function;

(iii) The clinical crown is fractured or destroyed by one-half or more; and

(iv) Endodontically treated teeth must have three (3) or more surfaces restored or lost due to carious activity to be considered for a crown.

(B) The conditions listed above in (A) (i) through (iv) should be clearly visible on the submitted images when a request is made for any type of crown.

(C) Routine build-up(s) for authorized crowns are included in the fee for the crown. Non authorized restorative codes may be used if available.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, there is invasion of the biologic width, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural

tooth structure. Cast dowel cores are not allowed for molar or pre-molar teeth.

(E) Prefomed post(s) and core build-up(s) are not routinely provided with crowns for endodontically treated teeth.

(F) Chart documentation must include the OHCA caries risk assessment form demonstrating member is at a low to moderate risk.

(G) Provider is responsible for replacement or repair of all crowns if failure is caused by poor laboratory processes or procedure by provider for forty-eight (48) months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or two (2) or more missing posterior teeth in the same arch for members sixteen (16) ~~through twenty (20) years of age~~ years of age and older. Provider must indicate which teeth will be replaced. Members must have improved oral hygiene documented for at least twelve (12) months in the provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up for a period of two (2) years post insertion.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of three (3) or more missing teeth in the same arch for members twelve (12) through sixteen (16) years of age. Provider must indicate tooth numbers to be replaced. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of medical necessity must be sent with prior authorization. Model should not be made or sent unless requested.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members seventeen (17) through twenty (20) years of age will be considered for this treatment. Destruction of healthy teeth to replace a single missing tooth is not considered medically necessary. Members must have excellent oral hygiene documented for at least eighteen (18) months in the requesting provider's records and submitted with prior authorization request to be considered. Provider is responsible for any needed follow up until member loses eligibility.

(7) **Periodontal scaling and root planing.** ~~Procedure is designed for the removal of calculus or tissue that is contaminated and may require anesthesia and some soft tissue removal. This procedure requires that each tooth have three (3) or more of the six point measurements four (4) millimeters or greater, and have multiple areas of image supported bone loss, subgingival calculus and must involve two (2) or more teeth per quadrant for consideration. This procedure is not allowed in conjunction with any other periodontal surgery.~~ Procedure involves instrumentation of the crown and root surfaces of the teeth to

remove plaque and calculus from these surfaces. This procedure requires that each tooth involved have one (1) or more of the six-point measurements (probing pocket depths) equivalent to five (5) millimeters or greater, and image supported alveolar bone loss. Subgingival calculus and inflammation must be demonstrated for consideration of scaling and root planing. A minimum of two (2) teeth per quadrant must be involved, with the appropriate CDT code usage for fewer than four (4) teeth per quadrant. This procedure is not allowed in conjunction with any other periodontal surgery. Four quadrants of scaling and root planing are not allowed with oral prophylaxis.

(8) **Scaling in the presence of generalized moderate or severe gingival inflammation.** Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation, as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (bone loss). This procedure is only performed after a comprehensive evaluation has been completed and is not performed in conjunction with a prophylaxis. Procedure is designed for removal of plaque, calculus and stain from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation as indicated by generalized suprabony pockets and bleeding on probing, in the absence of periodontitis (alveolar bone loss). Generalized supra- and sub-gingival calculus, and moderate to severe inflammation must be demonstrated, with probing pocket depths of and five (5) mm or greater. This procedure is intended for scaling of the entire mouth in lieu of oral prophylaxis, and is only performed after a comprehensive evaluation has been completed.

317:30-5-699. Restorations

(a) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per 24 months. Additional restorations may be authorized upon approval of OHCA in cases of trauma. Teeth receiving a restoration are eligible within three months for consideration of single crown if endodontically treated. Providers must document type of isolation used in treatment progress notes. The provider is responsible for follow-up or any required replacement of a failed restoration, if the member is currently SoonerCare eligible.

(1) The Oklahoma Health Care Authority utilization parameters allow only one (1) permanent restorative service to be provided per tooth per twenty-four (24) months.

(2) Additional restorations may be authorized upon approval of OHCA in cases of trauma.

(3) The provider is responsible for follow-up or any required

replacement of a failed restoration, if the member is currently SoonerCare eligible.

(4) Providers must document type of isolation used in treatment progress notes.

(5) For members who are under twenty-one (21) years of age and who are receiving a restoration are eligible within three (3) months for consideration of a single crown if endodontically treated.

(b) **Coverage for dental restorations.** Restoration of incipient lesions is not considered medically necessary treatment. Any diagnosis not supported by images requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered, for adults and children, as follows:

(1) If the mesial occlusal pit and the distal occlusal pit on an upper molar tooth are restored at the same appointment, this is a one (1) surface restoration.

(2) If any two (2) separate surfaces on a posterior tooth are restored at the same appointment, it is a two (2) surface restoration.

(3) If any three (3) separate surfaces on a posterior tooth are restored at the same appointment, it is a three (3) surface restoration.

(4) If the mesial, distal, facial and/or lingual of an upper anterior tooth is restored at the same appointment, this is a four (4) surface restoration.

(5) If any two (2) separate surfaces on an anterior tooth are restored at the same appointment, it is a two (2) surface restoration.

(6) If any three (3) separate surfaces on an anterior tooth are restored at the same appointment, it is a three (3) surface restoration.

(7) An incisal angle restoration is defined as one (1) of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. If any of these surfaces are restored at the same appointment, even if separate, it is considered as a single incisal angle restoration.

(8) When four (4) or more separate surfaces on a posterior tooth are restored at the same appointment it is a four (4) surface restoration.

(9) Wide embrasure cavity preparations do not become extra surfaces unless at least one half of cusp or surface is involved in the restoration. An MODFL restoration would have to include the mesial-occlusal-distal surfaces as well as either the buccal groove pit or buccal surface or at least one half the surface of one of the buccal cusps. The same logic applies for the lingual surface.

(a) Orthodontic services are available for members who are SoonerCare-eligible and under eighteen (18) years of age at the time the request for prior authorization for treatment is received.

In order to be eligible for SoonerCare orthodontic services, members must be referred through an OHCA contracted primary care dentist using the DEN-2 form found on the Oklahoma Health Care Authority (OHCA) website; a member can receive a referral from a primary care dentist to the orthodontist only after meeting the following:

- (1) The member has had a caries free initial visit; or
- (2) Has all decayed areas restored and has remained caries free for twelve 12 months; and
- (3) Has demonstrated competency in maintaining an appropriate level of oral hygiene.

(b) Member with cleft palate can be referred directly by their treating physician without a dental referral and are exempt from above requirements.

(c) The SoonerCare Orthodontic Program limits orthodontic services to handicapping malocclusions determined to be severe enough to warrant medically necessary treatment. The orthodontic provider has the ability to determine if members may qualify with a visual screening. Diagnostic record accumulation and/or submission should only occur for members with high potential for acceptance. These orthodontic services include the following:

- (1) A handicapping malocclusion, as measured on the Oklahoma Health Care Authority (OHCA) Handicapping Labio-Lingual Deviation Index of Malocclusion (DEN-6) form, with a minimum score of thirty (30);
- (2) Any classification secondary to cleft palate or other maxillofacial deformity;
- (3) If a single tooth or anterior crossbite is the only medical need finding, service will be limited to interceptive treatment;
- (4) Fixed appliances only; and
- (5) Permanent dentition with the exception of cleft defects.

(d) Reimbursement for orthodontic services is limited to:

- (1) Orthodontists, or
- (2) General or Pediatric dental practitioners who have completed at least two-hundred (200) certified hours of continuing education in the field of orthodontics practice and submit for review at least twenty-five successfully completed comprehensive cases. Of these twenty-five comprehensive cases, ten or more must be extraction cases. An applicant for this certification must practice in an OHCA deemed under-served area. The comprehensive cases submitted should be of a complexity consistent with type of handicapping malocclusion likely to be treated in the SoonerCare program.

(A) Cases submitted must include at least one (1) of each of the following types:

- (i) Deep overbite where multiple teeth are impinging upon the soft tissue of the palate;
- (ii) Impacted canine or molar requiring surgical exposure;
- (iii) Bilateral posterior crossbite requiring fixed rapid palatal expansion; and
- (iv) Skeletal class II or III requiring orthognathic surgery.

(B) As with all dental or orthodontia treatment performed and reimbursed by SoonerCare, all pre and post orthodontic records must be available for review.

(C) The OHCA requires all general dentists providing comprehensive orthodontic care to submit a copy of the Oklahoma Board of Dentistry continuing education report and verification that at least twenty (20) continuing education hours in the field of orthodontics has been completed per reporting period. All verification reports must be submitted to OHCA Dental Unit every three (3) years, no later than August 30. In addition, verification of adequate progress for all active orthodontic cases will be reviewed by the OHCA Dental Unit upon completion of twenty-four (24) months of therapy.

(e) The following limitations apply to orthodontic services:

- (1) Cosmetic orthodontic services are not a covered benefit of the SoonerCare program and no requests should be submitted;
- (2) All orthodontic procedures require prior authorization for payment;
- (3) Prior authorization for orthodontic treatment is not a notification of the member's eligibility and does not guarantee payment. Payment for authorized services depends on the member's eligibility at the beginning of each treatment year. Treatment year is determined by date of banding; and
- (4) The member must be SoonerCare-eligible and under eighteen (18) years of age at the time the request for prior authorization for treatment is received by the OHCA. Services cannot be added or approved after eligibility has expired. It is the orthodontist's responsibility to verify that the member has current SoonerCare eligibility and the date of birth indicates the member is under age eighteen (18).

(f) Orthodontic services are an elective procedure. The orthodontist must interview the prospective member as to his/her understanding of and willingness to cooperate fully in a lengthy treatment program.

(g) The interview information is unavailable to OHCA except through the provider's recommendation of treatment. The interview process for OHCA members is equivalent to that of private pay patients.

(h) Providers are not obligated to accept a member when it appears that the member will not cooperate in the orthodontic hygiene treatment program, does not return to the general dentist for preventive visits or is not willing to keep eligibility for SoonerCare current.

317:30-5-700.1. Orthodontic prior authorization

(a) Orthodontic services are available for members who are SoonerCare-eligible and under eighteen (18) years of age, at the time the request for prior authorization for treatment is received, per Oklahoma Administrative Code 317:30-5-700. The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be submitted to the Dental Unit of the Oklahoma Health Care Authority (OHCA) Dental Program when the member has a total score of not less than thirty (30) points or meets other eligibility criteria in paragraph (d).

- (1) Completed currently approved American Dental Association (ADA) dental claim form;
- (2) Complete and scored Handicapping Labio-Lingual Deviation (HDL) Index with Diagnosis of Angle's classification;
- (3) Detailed description of any oral maxillofacial anomaly;
- (4) Estimated length of treatment;
- (5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;
- (6) Cephalometric images with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;
- (7) Completed OHCA caries risk assessment form;
- (8) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service; and
- (9) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

(b) All images and required documentation must be submitted in one (1) package. OHCA is not responsible for lost or damaged materials.

(c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by the OHCA orthodontic consultant for compensability and length of treatment. Any documentation on which a decision is made will not be returned.

(d) Some children not receiving a minimum score of thirty (30) on the HDL Index may have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child, he/she refers to the conditions listed on the Early and Periodic

Screening, Diagnostic and Treatment (EPSDT) exception section found on the HLD. The following guidelines and restrictions apply to other conditions:

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child;

(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child;

(3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (e.g., a child's teacher, primary care physician, behavioral health provider, school counselor);

(4) Objective evidence must be submitted with the HLD;

(5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA orthodontic consultant must review the data and use his or her professional judgment to score the value of the conditions; and

(6) The OHCA orthodontic consultant may consult with and utilize the opinion of the orthodontist who completes the form.

(e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the member's age precludes approval, a computer generated notice is issued to the provider and member with notice of the denial, the reason for the denial, and appeal rights [see Oklahoma Administrative Code (OAC) 317:2-1 for grievance procedures and processes].

(f) Orthodontic treatment and payment for the services are approved within the scope of the SoonerCare program. If orthodontic treatment is approved, a computer generated notice is issued authorizing the first year of treatment.

(1) Approval of orthodontic treatment is given in accordance with the following:

(A) Authorization for the first year begins on the date of banding and includes the placement of appliances, arch wires, and a minimum of six (6) adjustments. It is expected that orthodontic members be seen every four (4) to eight (8) weeks for the duration of active treatment.

(B) Subsequent adjustments will be authorized in one (1) year intervals and the treating orthodontist must provide a comprehensive progress report at the twenty-four (24) month interval.

(C) All approved treatment is included on the original prior authorization and will include the total payment for that treatment year.

(2) Claim and payment are made as follows:

(A) Payment for comprehensive treatment includes the

banding, wires, adjustments as well as all ancillary services, including the removal of appliances, and the construction and placing of retainers.

(B) Payment is not made for comprehensive treatment beyond thirty-six (36) months.

(g) If the member moves from the geographic area or shows a need to change their provider, then the provider who received the yearly payment is financially responsible until completion of that member's orthodontic treatment for the current year.

(h) If the provider who received yearly payment does not agree to be financially responsible, then the OHCA may recoup funds paid for the member's orthodontic treatment.

(i) All orthodontic services are subject to post-utilization review. This review may include a request by the OHCA to submit medical documentation necessary to complete the review. After review is completed, these materials are returned to the orthodontist.

(j) ~~Study models~~ 3-D model images or oral/facial images must be diagnostic and meet the following requirements:

~~(1) Study models must be properly poured and adequately trimmed without large voids or positive bubbles present.~~

~~(2) Centric occlusion must be clearly indicated by pencil lines on the study models, making it possible to occlude the teeth on the models in centric occlusion.~~

~~(3) 3-D model images are preferred.~~

~~(4)~~ (1) All measurements are made or judged on the basis of greater than or more than the minimal criteria. Measurement, counting, recording, or consideration is performed only on teeth that have erupted and may be seen on the study models.

~~(5)~~ (2) For photographic images, the oral/facial portfolio must show a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(A) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(B) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

317:30-5-705. Billing and reimbursement

(a) Billing for dental services may be submitted on the currently approved version of the American Dental Association (ADA) claim form. Diagnosis codes are requested to be listed in box 34 of the current ADA dental claim form. Electronic submission must be made on the HIPPA compliant Form 837D.

(b) Billing and reimbursement methodology, including copayments,

are outlined in the Oklahoma Medicaid State Plan.

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