

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY  
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE  
SUBCHAPTER 3. GENERAL PROVIDER POLICIES  
PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS  
AND TREATMENT (EPSDT) PROGRAM/CHILD HEALTH SERVICES**

**317:30-3-65.8. Dental services**

(a) At a minimum, dental services include relief of pain and infection; limited restoration of teeth and maintenance of dental health; and oral prophylaxis every 184 days. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. Other dental services include inpatient services in an eligible participating hospital, amalgam anterior and composite composites and posterior amalgam restorations, pulpotomies, chrome steel crowns, anterior root canals, pulpectomies, band and loop space maintainers, cement bases, acrylic partial and lingual arch bars; other restoration, repair and/or replacement of dental defects after the treatment plan submitted by a dentist has been authorized (refer to OAC 317:30-5-696(3) for amount, duration and scope).

(b) Dental screens should begin at the first sign of tooth eruption by the primary care provider and with each subsequent visit to determine if the child needs a referral to a dental provider. Dental examinations by a qualified dental provider should begin before ~~between~~ the ~~ages~~ age of two ~~and three~~ (unless otherwise indicated) and once yearly thereafter. Additionally, children should be seen for prophylaxis once every 184 days- , if indicated by risk assessment. All other dental services for relief of pain and infection, restoration of teeth and maintenance of dental health should occur as the provider deems necessary.

(c) Separate payment will be made to the member's primary care provider for the application of fluoride varnish during the course of a well child screening for members ages 12 months to 42 months. Reimbursement is limited to two applications per year by eligible providers who have attended an OHCA-approved training course related to the application of fluoride varnish.

**CHAPTER 30.MEDICAL PROVIDERS-FEE FOR SERVICE  
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES  
PART 79.DENTISTS**

**317:30-5-695. Eligible dental providers and definitions**

(a) Eligible dental providers in Oklahoma's SoonerCare program are:

- (1) individuals licensed as dentists under 59 Oklahoma Statutes § § 328.21, 328.22, and 328.23 (licensed dentists, specialty dentists and out of state dentists);
- (2) individuals issued permits as dental interns under 59 Oklahoma Statute § 328.26;
- (3) individuals who are third and fourth year dental students at an accredited Oklahoma dental college; and
- (4) any individual issued a license in another state as a dentist.

(b) All eligible providers must be in good standing with regard to their license. Any revocation or suspension status of a provider referenced in subsection (a) above renders the provider ineligible for payment or subject to recoupment under SoonerCare.

(c) Eligible providers must document and sign records of services rendered in accordance with guidelines found at OAC 317:30-3-15.

(d) The American Dental Association's version of Current Dental Terminology (CDT) is used by the OHCA to communicate information related to codes, and procedures for administration. Definitions, nomenclature, and descriptors as listed in the CDT will apply, with the exception of more specific definitions or limitations set forth.

(1) "Decay" means carious lesions in a tooth; decomposition and/or dissolution of the calcified and organic components of the tooth structure.

(2) "Emergency Dental Care" includes, but is not limited to, the immediate service that must be provided to relieve the member from pain due to an acute infection, swelling, trismus or trauma.

~~(2)~~(3) "Palliative Treatment" means action that relieves pain but is not curative. Palliative Treatment is an all inclusive service. No other codes are ~~billable~~ reimbursable on the same date of service.

~~(3)~~(4) "Radiographic Caries" means dissolution of the calcified and organic components of tooth tissue that has penetrated the enamel and is approaching the dentinoenamel junction.

~~(4)~~(5) "Upcoding" means reporting a more complex and/or higher cost procedure than actually performed.

~~(5)~~(6) "Unbinding" means billing separately for several individual procedures that are included within one Current Dental Terminology or Current Procedural Terminology (CPT) code.

**317:30-5-696. Coverage by category**

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

**(1) Adults.**

(A) Dental coverage for adults is limited to:

- (i) emergency extractions;
- (ii) Smoking and Tobacco Use Cessation Counseling; and
- (iii) medical and surgical services performed by a dentist, to the extent such services may be performed under State law either by a doctor of dental surgery or dental medicine, 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 the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care, similar to the scope of services available to individuals under age 21.

(C) Pregnant women are covered under a limited dental benefit plan (Refer to (a)(4) of this Section).

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

**(3) Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 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. 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.** ~~Evaluation must be performed and recorded for each new patient, or established patient not seen for more than 18 months. This procedure is allowed once each 18 month period. This procedure is performed for any member not seen by any dentist for more than 12 months.~~

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if she or he has not been seen for more than six months.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of

a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint.

~~(D) **Oral hygiene instructions.** This service is limited to once every 12 months. The designated dental staff instructs the member or the responsible adult (if the child is under five years of age) in proper tooth brushing and flossing by actual demonstration and provides proper verbal and/or written diet information. This service also includes dispensing a new tooth brush, and may include disclosing tablets and dental floss.~~

~~(E)~~(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include patient member history, prior radiographs, caries risk assessment and both dental and general health needs of the patient member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Panoramic films are allowable once in a three year period and must be of diagnostic quality. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

~~(F)~~(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on all the interproximal and occlusal surfaces to be eligible for this service. This service is available through ~~18-0~~ 18 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

~~(G)~~(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

~~(H)~~(G) **Composite restorations.**

(i) This procedure is compensable for primary incisors as follows:

(I) tooth numbers O and P to age ~~4-0~~ 4 years;

(II) tooth numbers E and F to age ~~6-0~~ 6 years;

(III) tooth numbers N and Q to ~~5-0~~ 5 years;  
and

(IV) tooth numbers D and G to ~~6-0~~ 6 years.

(ii) The procedure is also allowed for use in all vital and successfully treated non-vital permanent anterior teeth.

(iii) Class I and II composite restorations are allowed in posterior teeth; however, the OHCA has certain restrictions for the use of this restorative material. (See OAC 317:30-5-699).

~~(I)~~(H) **Amalgam.** Amalgam restorations are allowed in:

(i) posterior primary teeth when:

(I) 50 percent or more root structure is remaining;

(II) the teeth have no mobility; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) any permanent tooth, determined as medically necessary by the treating dentist.

~~(J)~~(I) **Stainless steel crowns.** The use of stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) the child is five years of age or under;

(II) 70 percent or more of the root structure remains; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) primary teeth with pulpotomies or pulpectomies, if the above conditions exist;

(II) primary teeth where three surfaces of extensive decay exist; or

(III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Stainless steel crowns are the treatment of choice on posterior permanent teeth that have completed endodontic therapy, if more than three surfaces of extensive decay exist or where cuspal occlusion are lost due to decay prior to age ~~16-0~~ 16 years.

(iv) Preoperative periapical x-rays must be available for review, if requested.

(v) Placement of a stainless steel crown includes all related follow up service for a period of two

years. No other prosthetic procedure 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.

~~(K)~~(J) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies are allowable for molars and teeth numbers listed below. Pre and post operative periapical x-rays must be available for review, if requested.

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

(II) Tooth numbers O and P before age ~~5-0~~ 5 years;

(III) Tooth numbers E and F before ~~6-0~~ 6 years;

(IV) Tooth numbers N and Q before ~~5-0~~ 5 years; and

(V) Tooth numbers D and G before ~~6-0~~ 5 years.

(ii) Pulpectomies are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

~~(L)~~(K) **Anterior root canals.** Payment is made for the services provided in accordance with the following:

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

(ii) Acceptable ADA filling materials must be used.

(iii) Preauthorization is required if the member's treatment plan involves more than four anterior root canals.

(iv) Teeth with less than 50 percent of clinical crown should not be treatment-planned for root canal therapy.

(v) Pre and post operative periapical x-rays must be available for review.

(vi) Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA.

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

(viii) Endodontic 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.

(ix) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed.

~~(M)~~(L) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six 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 5mm below the crest of the alveolar ridge or where the successor tooth would not normally erupt in the next 12 months.

(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 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 x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four 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 where when permanent incisors are erupted and multiple missing teeth exist in the same arch.

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

(III) Multiple missing upper anterior primary incisors may be replaced with the appliance to age ~~6.0~~ 6 years to prevent abnormal swallowing habits.

(IV) Pre and post operative x-rays must be available.

(iii) **Interim partial dentures.** This service is for anterior permanent tooth replacement or if the member is missing three or more posterior teeth to age ~~16.0~~ 16 years of age.

~~(N)~~(M) **Analgesia.** ~~Use of nitrous oxide is compensable for four occurrences per year. Analgesia services are reimbursable in accordance with the following:~~

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The need for this service must be documented in the member's record. This procedure is not covered when it is the dentist's usual practice to offer it to all patients.

(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.

~~(O)~~(N) **Pulp caps (direct).** ~~ADA accepted CAOH containing material must be used. Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. 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.~~



~~(P)~~(O) **Sedative treatment restorations.** ADA acceptable materials must be used for temporary restoration. This restoration is used for very deep cavities to allow the tooth an adequate chance to heal itself or an attempt to prevent the need for root canal therapy. This restoration, when properly used, is intended to relieve pain and may include a direct or indirect pulp cap. The combination of a pulp cap and sedative fill is the only restorative procedure allowed per tooth per day. Subsequent restoration of the tooth is allowed after a minimum of 30 days. Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These services are reimbursable for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

~~(Q)~~(P) **History and physical.** Payment is made for services for the purpose of admitting a patient to a hospital for dental treatment.

~~(R)~~(Q) **Local anesthesia.** This procedure is included in the fee for all services.

~~(S)~~(R) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the patient member to describe his/her smoking, advising the patient member to quit, assessing the willingness of the patient member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight 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, nurse midwives, and Oklahoma State Health Department and FQHC nursing staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the patient member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(4) **Pregnant Women.** Dental coverage for this special population is provided regardless of age.

(A) Proof of pregnancy is required (Refer to OAC 317:35-5-6).

(B) Coverage is limited to a time period beginning at the diagnosis of pregnancy and ending upon 60 days post partum.

(C) In addition to dental services for adults, other services available include:

(i) Comprehensive oral evaluation must be performed and recorded for each new ~~client~~ member, or established ~~client~~ member not seen for more than 24 months;

(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(3)(B);

(iii) Emergency examinations/limited oral evaluation. This procedure is not allowed within two months of an oral examination by the same provider for the same ~~patient~~ member, or if the ~~patient~~ member is under active treatment;

~~(iv) Oral hygiene instructions as defined in OAC 317:30-5-696(a)(3)(E);~~

~~(v)(iv) Radiographs as defined in OAC 317:30-5-696(a)(3)(F) OAC 317:30-5-696(3)(D);~~

~~(vi)(v) Dental prophylaxis as defined in OAC 317:30-5-696(a)(3)(H) OAC 317:30-5-696(3)(F);~~

~~(vii)(vi) Composite restorations:~~

(I) Any permanent tooth that has an opened lesion that is a food trap will be deemed medically necessary for this program and will be allowed for all anterior teeth.

(II) Class I posterior composite resin restorations are allowed in posterior teeth that qualify;

~~(viii)(vii) Amalgam. Any permanent tooth that has an opened lesion that is a food trap will be deemed as medically necessary and will be allowed; and~~

~~(ix)(viii) Analgesia. Use of nitrous oxide is compensable for four occurrences. Analgesia services are reimbursable in accordance with OAC 317:30-5-696(iii)(M).~~

(D) Services requiring prior authorization (Refer to OAC 317:30-5-698).

(E) Periodontal scaling and root planing. Required that 50% or more of six point measurements be 4 5 millimeters or greater. This procedure is designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins and microorganism and requires anesthesia and some soft tissue removal.

(5) **Individuals eligible for Part B of Medicare.**

(A) Payment is made based on the member's coinsurance and deductibles.

(B) Services which have been denied by Medicare as non-compensable should be filed directly with the OHCA with a copy of the Medicare EOB indicating the reason for denial.

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

(a) Providers must have prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis (See OAC 317:30-5-695(d)(2)). ~~Emergency dental care is immediate service that must be provided to relieve the member from pain due to an acute infection, swelling, trismus or trauma.~~ Requests for dental services requiring prior authorization must be accompanied by sufficient documentation. ~~Study models (where indicated), x-rays~~ X-rays, six point periodontal charting, and comprehensive treatment plan plans are required. Study models and narrative narratives may be requested by OHCA or representatives of OHCA. If the quality of the supporting material is such that a determination of authorization cannot be made, the material is returned to the provider. Any new documentation must be provided at the provider's expense. Submitted documentation used to base a decision will not be returned.

(b) Requests for prior authorization are filed on the currently approved ADA form. OHCA notifies the provider on the determination of prior authorization using OHCA Prior Authorization Request Decision 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 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) Listed below are examples of services requiring prior authorization for members under 21 and eligible ICF/MR residents. Minimum required records to be submitted with each request are right and left mounted bitewing x-rays and periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings. ~~X-rays must be mounted so that they are viewed from the front of the member. If required x-rays sent are copies,~~ submitted with x-ray film mounts and each film or print must be of good, readable quality. X-rays must be and identified by as to left and right sides with the date, member name, member ID, provider name, and provider ID. All x-rays, regardless of the media, must be placed together in the

same envelope with a completed comprehensive treatment plan and a completed current ADA form requesting all treatments requiring prior authorization. The film, digital media or printout must be of sufficient quality to clearly show the requested service area of interest demonstrate for the reviewer, the pathology which is the basis for the authorization request. X-rays must be identified with member name, date, member ID number, provider name, and provider ID number and as right or left side. X-rays must be placed together in an envelope and stapled to the submission form. If radiographs are not taken, provider must include in narrative sufficient information to confirm diagnosis and treatment plan.

(1) **Endodontics.** Pulpotomy may be performed for the relief of pain while waiting for the decision from the OHCA on request for endodontics. A permanent restoration is not billable to the OHCA when performing pulpotomy or pulpal debridement on a permanent tooth.

(A) **Anterior root canals.** This procedure is for members whom, by the provider's documentation, who have a treatment plan requiring more than four anterior ~~root canals~~ and/or posterior ~~endodontics~~ root canals. Payment is made for services provided in accordance with the following:

(i) Permanent teeth numbered 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27 are eligible for therapy if there are no other missing teeth in the same arch requiring replacement, unless numbers 6, 11, 22, or 27 are abutments for prosthesis.

(ii) Accepted ADA filling materials must be used.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 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.

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

(vii) If there are three or more missing teeth in the arch that requires replacement, root therapy will not be allowed authorized.

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

(i) The provider documents that the member has improved oral hygiene and flossing ability in this member's records.

(ii) Teeth that would require pre-fabricated post and cores to ~~minimally~~ retain a ~~crown~~ restoration due to lack of natural tooth structure should not be treatment planned for root canal therapy.

(iii) Pre and post operative periapical x-rays must be available for review.

(iv) Providers are responsible for any follow-up treatment required by a failed endodontically treated tooth within 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 ~~filling~~ materials are acceptable under the OHCA policy.

(vii) Posterior endodontic procedure is limited to a maximum of five teeth. A request 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) there are missing teeth in the same arch requiring replacement;

(II) an opposing tooth has super erupted;

(III) loss of tooth space is one third or greater;

(IV) opposing second molars are involved unless prior authorized; or

(V) the member has multiple teeth failing due to previous inadequate root canal therapy or follow-up.

(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.

(x) a ~~single~~ failing root canal is determined not medically necessary for re-treatment.

(2) **Cast metal crowns or ceramic-based crowns.** These procedures are compensable for restoration of natural teeth for members who are 16 years of age or older and adults residing in private Intermediate Care Facilities for the Mentally Retarded(ICF/MR) and who have been approved for

(ICF/MR) level of care. Certain criteria and limitations apply.

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

(i) The tooth must be fractured or decayed to such an extent to prevent proper cuspal or incisal function.

(ii) The clinical crown is destroyed by the above elements by one-half or more.

(iii) Endodontically treated teeth must have three or more surfaces restored or lost due to carious activity to be considered.

(B) The conditions listed in (A)(i) through (A)(iii) of this paragraph should be clearly visible on the submitted x-rays 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.

(D) A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed.

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

(F) Ceramic-metal based crowns will be considered only for tooth numbers 4 through 13 and 21 through 28.

(G) Porcelain/Ceramic substrate crowns are allowed on maxillary and mandibular incisors only.

~~(G)~~ (H) Full cast metal crowns are treatment of choice for all posterior teeth,

~~(H)~~ (I) Provider is responsible for replacement or repair of all cast crowns if due to failure caused by poor laboratory processes or procedure by provider for 48 months post insertion.

(3) **Cast frame partial dentures.** This appliance is the treatment of choice for replacement of three or more missing permanent teeth in the same arch for members 16 through 20 years of age. Provider must indicate tooth number to be replaced and teeth to be clasped.

(4) **Acrylic partial.** This appliance is the treatment of choice for replacement of missing anterior permanent teeth or three or more missing teeth in the same arch for members 12 through 16 years of age and adults residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and who have been approved for ICF/MR level of care. Provider must indicate tooth numbers to be replaced and teeth

to be clasped. This appliance includes all necessary clasps and rests.

(5) **Occlusal guard.** Narrative of clinical findings must be sent with prior authorization request.

(6) **Fixed cast non-precious metal or porcelain/metal bridges.** Only members 17 through 20 years of age where the bite relationship precludes the use of ~~an acrylic or cast frame partial denture~~ removable partial dentures are considered. ~~Study models with narrative are required to substantiate need for fixed bridge(s).~~ Members must have excellent oral hygiene documented in the requesting provider's records. Provider is responsible for any needed follow up for a period of five years post insertion.

(7) **Periodontal scaling and root planing.** This procedure requires that 50% or more of the six point measurements be ~~four~~ five millimeters or greater and must involve two or more teeth per quadrant for consideration. This procedure is allowed on members 12 to 20 years of age and requires anesthesia and some soft tissue removal. The procedure is not allowed in conjunction with any other periodontal surgery. Allowance may be made for submission of required authorization data post treatment if the member has a medical or emotional problem that requires sedation.

(8) **Additional prophylaxis.** The OHCA recognizes that certain physical conditions require more than two prophylaxes. The following conditions may qualify a member for one additional prophylaxis per year:

- (A) dilantin hyperplasia;
- (B) cerebral palsy;
- (C) mental retardation;
- (D) juvenile periodontitis.

### **317:30-5-699. Restorations**

(a) **Use of posterior composite resins.** Payment is not made for certain restorative services when posterior composite resins are used in restorations involving:

- (1) replacement of any occlusal cusp; or
- (2) sub-gingival margins; ~~and~~
- ~~(3) a restoration replacing more than 50 percent of the dentin.~~

(b) **Utilization parameters.** The Oklahoma Health Care Authority utilization parameters allow only one permanent restorative service to be provided per tooth per ~~12~~ 18 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 use of rubber dam isolation in

daily 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. Fees paid for the original restorative services may be recouped if any additional treatments are required on the same tooth by a different provider within 12 months due to defective restoration or recurrent decay. If it is determined by the Dental Director that a member has received poorly rendered or insufficient treatment from a provider, the Dental Director may prior authorize corrective procedures by a second provider.

(c) **Coverage for dental restorations.** Restoration of incipient lesions is not considered medically necessary treatment. Any diagnosis not supported by radiographs requires documentation of the medical need on which the diagnosis was made. Services for dental restorations are covered 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 surface restoration.
- (2) If any two separate surfaces on a posterior tooth are restored at the same appointment, it is a two surface restoration.
- (3) If any three separate surfaces on a posterior tooth are restored at the same appointment, it is a three 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 surface restoration.
- (5) If any two separate surfaces on an anterior tooth are restored at the same appointment, it is a two surface restoration.
- (6) If any three separate surfaces on an anterior tooth are restored at the same appointment, it is a three surface restoration.
- (7) An incisal angle restoration is defined as one 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 or more separate surfaces on a posterior tooth are restored at the same appointment it is a four 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.

(d) **Sedative restorations.** Sedative restorations include removal of decay, if present, and direct or indirect pulp cap, if needed. These two codes are the only codes that may be used for the same tooth on the same date of service. Permanent restoration of the tooth is allowed after 30 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(e) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted materials, not a cavity liner. Indirect pulp cap code requires specific narrative support addressing materials used, intent and reasons for use. Utilization of these codes are verified on a post payment review.

### 317:30-5-700. Orthodontic services

(a) In order to be eligible for SoonerCare Orthodontic services, members must be referred through a primary care dentist; 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) ~~the member has been fully restored and has received post operative treatment;~~ has all decayed areas restored and has received a six month hygiene evaluation indicating the member remains caries free; and
- (3) ~~the member has received a six month hygiene evaluation indication no additional treatments are required;~~
- (4) ~~the member remains caries free for one year; and~~
- (5) ~~the member is in good gingival health.~~

(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.

~~(b)~~(c) The Oklahoma 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 Handicapping Labio-Lingual Deviation Index (HLD) with a minimum score of 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.

~~(e)~~(d) Reimbursement for Orthodontic services is limited to:

(1) Orthodontists, or

(2) General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice ~~in an under served area~~, and submit for review at least 25 successfully completed comprehensive cases. Of these 25 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 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.

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

~~(B)~~(C) Verification of the continuing education hours and the number of cases completed are reviewed by the OHCA Dental Unit every two years.

~~(d)~~(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;

(4) The member must be SoonerCare eligible and under 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:

(A) Members receive a permanent Medical Identification Card;

(B) 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 18.

~~(e)~~(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.

~~(f)~~(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.

~~(g)~~(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) 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 OHCA when the member has a total score of not less than 30 points or meets other eligibility criteria in paragraph (d).

- (1) Completed currently approved ADA dental claim form;
- (2) Completed and scored Handicapping Labio-Lingual Deviations Index with Diagnosis of Angle's classification;
- (3) Detailed description of any ~~oromaxillofacial~~ 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 x-rays with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;
- (7) 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;
- (8) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

(b) All images, x-rays, and required documentation must be submitted in one 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 30 on the Handicapping Labio-Lingual Deviation Index (HLD) 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 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 (i.e., 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.

(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 with notice of the denial, the reason for the denial, and appeal rights (see OAC 317:2-1 for grievance procedures and process).

(f) Orthodontic treatment and payment for the services are approved within the scope of SoonerCare. 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 includes the placement of appliances, arch wires, and a minimum of six adjustments. It is expected that orthodontic members be seen every four to eight weeks for the duration of active treatment.

(B) Subsequent adjustments will be authorized in one year intervals and the treating orthodontist must provide a comprehensive progress report at the 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 the first year of treatment includes the banding, wires, and 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 36 months.

~~(g) Relative Value Units (RVU's) have been developed by OHCA for the first year's treatment and each subsequent year's treatment. The allowable charge is computed by multiplying the RVU by the current conversion factor.~~

~~(h)~~(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.

~~(i)~~(h) If the provider who received yearly payment does not agree to be financially responsible, then the Oklahoma Health Care Authority will recoup funds paid for the member's orthodontic treatment.

~~(j)~~(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.

~~(k)~~(j) Study models 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) Study models not in compliance with the above described diagnostic guidelines are not accepted. The provider may send new images that meet these requirements. If the

provider does not respond, the request for treatment is denied.

(5) 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.