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.**

(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.

(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.

(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) **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 history, prior radiographs, caries risk assessment and both dental and general health needs of the patient. 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) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on all surfaces to be eligible for this service. This service is available through 18.0 years of age and is compensable only once per lifetime. Replacement of sealants is not a covered service under the SoonerCare program.

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

(H) **Composite restorations.**

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

(I) tooth numbers O and P to age 4.0 years;
(II) tooth numbers E and F to age 6.0 years;
(III) tooth numbers N and Q to 5.0 years; and
(IV) tooth numbers D and G to 6.0 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) **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) **Stainless steel crowns.** The use of stainless steel crowns is allowed as follows:
(i) Stainless steel crowns are allowed if the child is five years of age or under, and 70 percent or more of the root structure remains or the tooth is not expected to exfoliate within the next 12 months.
(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 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) **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 years;
(III) Tooth numbers E and F before 6.0 years;
(IV) Tooth numbers N and Q before 5.0 years; and
(V) Tooth numbers D and G before 6.0 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) **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) **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.

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

(I) Lingual arch bar is used where 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 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 years of age.

(N) **Analgesia.** Use of nitrous oxide is compensable for four occurrences per year.

(O) **Pulp caps (direct).** ADA accepted CAOH containing material must be used.

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

~~(Q)~~(P) **Sedative treatment.** 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.

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

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

~~(T)~~(S) **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 to describe his/her smoking, advising the patient to quit, assessing the willingness of the patient 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 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, or established client not seen for more than 24 months;

(ii) Periodic oral evaluation as defined in OAC 317:30-5-696(a)(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 client, or if the client is under active treatment;

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

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

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

(vii) 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) 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) Analgesia. Use of nitrous oxide is compensable for four occurrences.

(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 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 noncompensable 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. 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, six point periodontal charting, comprehensive treatment plan and narrative may be requested. 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.

(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, each film or print must be of good, readable quality and identified as to left and right sides. The film must clearly show the requested service area of interest. X-rays must be identified with member name, date, member ID number, provider name, and provider number. 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, have a treatment plan requiring more than four anterior root canals and/or posterior endodontics. 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 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.

(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 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.

(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; or

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

(ix) Endodontically treated teeth must be restored to limited occlusal function and all contours must be replaced. 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. ~~This procedure is~~ 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) Full cast metal crowns are treatment of choice for all

posterior teeth.

(H) Provider is responsible for replacement or repair of cast crowns 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.

~~(5)~~ (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 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.

~~(6)~~ (7) Periodontal scaling and root planing. This procedure requires that 50% or more of the six point measurements be four 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.

~~(7)~~ (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;
(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 months. 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. 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.** 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. Utilization of these codes are verified on a post payment review.