
POLICY TRANSMITTAL NO. 08-37	DATE: JULY 23, 2008
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS AND POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:30-5-211.3; 30-5-211.8 through 30-5-211.12; 30-5-217 through 30-5-218; 30-5-547; 30-5-695 through 30-5-696; and 30-5-698.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

Revising Medical Suppliers rules to: (1) reorganize and be more user friendly by adding definitions and separating services; (2) include supplier accreditation, medical necessity, prescription, documentation, and prior authorization requirements; (3) address rental, purchase, repairs, maintenance, replacement, and delivery of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); (4) allow SoonerCare members freedom of provider choice; and (5) provide guidelines for new billing and reimbursement requirements. Additional revisions were made to emergency rules during permanent rulemaking. Previous rule revisions required arterial blood gas analysis (ABG) for initial requests for oxygen for adults. Although ABG results are a better test to determine medical necessity than pulse oximetry results, ABG is a more invasive test and providers were having a much more difficult time obtaining the test. Therefore, it was determined that resting pulse oximetry results were adequate and current rule revisions remove this requirement and allow ABG **or** resting oximetry results. Small wording changes were made to the prior authorization and oxygen rental sections. In addition, we also moved the requirement that the supplier include a copy of the invoice documenting the supplier's cost from the reimbursement section to the billing section. Both were for clarification purposes.

Dental rules are revised to: (1) require a clinical examination preceding any radiographs, and consideration of patient history, prior radiographs, caries risk assessment and dental and general health needs of the patient; (2) add definitions for certain terminology; and (3) clarify that permanent restoration is not billable to the OHCA when performing pulpotomy or pulpal debridement on a permanent tooth.

Original signed on 7-22-08

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WF # 08-L (NAP)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following an "OKDHS" number, such as personnel policy at OKDHS:2-1 and personnel rules at OAC 340:2-1. The "340" is the Title number that designates OKDHS as the rulemaking agency; the "2" specifies the Chapter number; and the "1" specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, OKDHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, OKDHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at 405-521-4326.

REMOVE

INSERT

317:30-5-211.3	317:30-5-211.3, 1 page only, revised 5-25-08
317:30-5-211.8	317:30-5-211.8, 1 page only, revised 5-25-08
317:30-5-211.9	317:30-5-211.9, 1 page only, revised 5-25-08
317:30-5-211.10	317:30-5-211.10, 1 page only, revised 5-25-08
317:30-5-211.11	317:30-5-211.11, pages 1-2, revised 5-25-08
317:30-5-211.12	317:30-5-211.12, 1 page only, revised 5-25-08
317:30-5-217	317:30-5-217, 1 page only, revised 5-25-08
317:30-5-218	317:30-5-218, 1 page only, revised 5-25-08
317:30-5-547	317:30-5-547, 1 page only, revised 5-25-08
317:30-5-695	317:30-5-695, 1 page only, revised 5-1-08
317:30-5-696	317:30-5-696, pages 1-7, revised 5-1-08
317:30-5-698	317:30-5-698, pages 1-4, revised 5-1-08

317:30-5-211.3. Prior authorization (PA)

(a) **General.** Prior authorization is the electronic or written authorization issued by OHCA to a provider prior to the provision of a service.

(b) **Requirements.** Billing must follow correct coding guidelines as promulgated by CMS or per uniquely and publicly promulgated OHCA guidelines. DME claims must include the most appropriate HCPCS code as assigned by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) or its successor. Authorizations for services not properly coded will be denied. **The**

following services require prior authorization:

- (1) services that exceed quantity/frequency limits;
- (2) medical need for an item is beyond OHCA's standards of coverage;
- (3) use of a Not Otherwise Classified (NOC) code or miscellaneous codes;
- (4) services for which a less costly alternative may exist; and
- (5) procedures indicating PA is required on the OHCA fee schedule.

(c) **Prior authorization requests.** Refer to OAC 317:30-5-216.

317:30-5-211.8. Coverage

Durable medical equipment, adaptive equipment, medical supplies and prosthetic devices prescribed by the appropriate medical provider and medically necessary are covered for adults and children as set forth in coverage guidelines.

317:30-5-211.9. Adaptive equipment

(a) **Residents of ICF/MR facilities.** Payment is made for customized adaptive equipment for persons residing in private Intermediate Care Facilities for the Mentally Retarded (ICF/MR). This means customized equipment or devices to assist in ambulation. Standard wheelchairs, walkers, eyeglasses, etc. would not be considered customized adaptive equipment. All customized adaptive equipment must be prescribed by a physician and requires prior authorization.

(b) **Members in home and community-based waivers.** Refer to OAC 317:40-5-100.

317:30-5-211.10. Durable medical equipment (DME)

(a) **DME.** DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment and other qualifying items when acquired from a contracted DME provider.

(b) **Certificate of medical necessity.** Certain items of DME require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include but are not limited to:

- (1) hospital beds;
- (2) support surfaces;
- (3) wheelchairs;
- (4) continuous positive airway pressure devices (BiCAP and CPAP);
- (5) patient lift devices;
- (6) external infusions pumps;
- (7) enteral and parenteral nutrition;
- (8) osteogenesis stimulators; and
- (9) pneumatic compression devices.

(c) **Prior authorization.**

(1) **Rental.** Rental of hospital beds, support surfaces, wheelchairs, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record and be signed by the physician.

(2) **Purchase.** Equipment will be purchased when a member requires the equipment for an extended period of time. During the prior authorization review the PA consultant may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.

(d) **Backup equipment.** Backup equipment is considered part of the rental cost and not a covered service without prior authorization.

(e) **Home modification.** Equipment used for home modification is not a covered service.

317:30-5-211.11. Oxygen and oxygen equipment

(a) **Medical necessity.** Oxygen and oxygen supplies are covered when medically necessary. Medical necessity is determined from results of arterial blood gas analysis (ABG) or pulse oximetry tests (pO₂). The test results to document medical necessity must be within 30 days of the date of the physician's prescription. A copy of a report from an inpatient or outpatient hospital or emergency room setting will meet the requirement.

(1) For initial certification for oxygen, the ABG study or oximetry analysis used to determine medical necessity may not be performed by the DMEPOS or a related corporation. In addition, neither the study nor the analysis may be performed by a physician with a significant ownership interest in the DMEPOS performing such tests. These prohibitions include relationships through blood or marriage. A referring physician may perform the test in his/her office as part of routine member care.

(2) Initial certification is for no more than three months. Except in the case of sleep-induced hypoxemia, ABG or oximetry is required within the third month of the initial certification period if the member has a continued need for supplemental oxygen. Re-certification will be required every 12 months.

(A) **Adults.** Initial requests for oxygen must include ABG or resting oximetry results. The arterial blood saturation can not exceed 89% at rest on room air; the pO₂ level can not exceed 59mm Hg.

(B) **Children.** Requests for oxygen for children that do not meet the following requirements should include documentation of the medical necessity based on the child's clinical condition and are considered on a case-by-case basis. Members 20 years of age or less must meet the following requirements:

- (i) birth through three years, SaO₂ level equal to or less than 94%; and
- (ii) ages four and above, SaO₂ level equal to or less than 90%.

(b) Certificate of medical necessity.

(1) The medical supplier must have a fully completed current CMN on file to support the claims for oxygen or oxygen supplies, to establish whether coverage criteria are met and to ensure that the oxygen services provided are consistent with the physician's prescription (refer to instructions from Palmetto Government Benefits Administration, the Oklahoma Medicare Carrier, for further requirements for completion of the CMN).

(2) The CMN must be signed by the physician prior to submitting

the initial claim. When a physician prescription for oxygen is renewed, a CMN, including the required retesting, must be completed by the physician prior to the submission of claims. The medical and prescription information on the CMN may be completed by a non physician clinician, or an employee of the physician for the physician's review and signature. In situations where the physician has prescribed oxygen over the phone, it is acceptable to have a cover letter containing the same information as the CMN, stating the physician's orders, as long as the CMN has been signed by the physician or as set out above.

(3) Prescription for oxygen services must be updated at least annually and at any time a change in prescription occurs during the year. All DMEPOS suppliers are responsible for maintaining the prescription(s) for oxygen services and CMN in each member's file. If any change in prescription occurs, the physician must complete a new CMN that must be maintained in the member's file by the DME supplier. The OHCA or its designated agent will conduct ongoing monitoring of prescriptions for oxygen services to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

(1) Oxygen concentrators are covered items for members residing in their home or in a nursing facility.

(2) For members who meet medical necessity criteria, SoonerCare covers portable oxygen and portable oxygen content. The need for portable oxygen must be stated on the CMN. A portable system that is used as a standby only is not a covered item.

(3) When six or more liters of oxygen are medically necessary, an additional payment will be paid up to 150% of the allowable for a stationary system when billed with the appropriate modifier.

317:30-5-217. Billing

(a) **Procedure codes.** It is the supplier's responsibility to ensure that claims for the supply or equipment are submitted with the most appropriate HCPCS code as assigned by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) or its successor. When the most appropriate procedure code is not used, the claim will be denied. When a specific procedure code has not been assigned to an item, an invoice is required which must contain a full description of the equipment or supply.

(b) **Rental.** Claims for rental should indicate the first date of service and the inclusive dates of rental as part of the description of services. The appropriate modifier must be included. Only one month's rental should be entered on each detail line.

(c) **Invoice.** Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(d) **Place of service.** The appropriate indicator for the patient's place of residence must be entered.

(e) **Prescribing provider.** The name of the prescribing provider must be included for claims processing and entered in the appropriate block.

(f) Items must be received by the member before billing OHCA.

317:30-5-218. Reimbursement

(a) **Medical equipment and supplies.** Reimbursement for durable medical equipment and supplies will be made using an amount derived from the lesser of the OHCA maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established based on efficiency, economy, and quality of care as determined by the OHCA.

(b) **Oxygen equipment and supplies.**

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Content for portable systems should be billed monthly with one unit equal to one month's supply. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.

(3) Effective July 1, 2007, payment for oxygen equipment and supplies will be based on the Medicaid allowable in effect for the Oklahoma region on June 30, 2007. The fee schedule will be reviewed annually; adjustments to the fee schedule may be made based on efficiency, budget considerations, and quality of care as determined by the OHCA.

317:30-5-547. Reimbursement

(a) Nursing services and home health aide services are covered services on a per visit basis. Reimbursement for any combination of nursing or home aid service shall not exceed 36 visits per calendar year per member. Additional visits for children must be prior authorized when medically necessary.

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the OHCA fee schedule or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure code. When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established based on efficiency, economy, and quality of care as determined by the OHCA. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. Content for portable systems should be billed monthly with one unit equal to one month's supply. Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.

(3) Effective July 1, 2007, payment for oxygen equipment and supplies will be based on the Medicaid allowable rates in effect for the Oklahoma region on June 30, 2007. The fee schedule will be reviewed annually; adjustments to the fee schedule may be made based on efficiency, budget considerations, and quality of care as determined by the OHCA.

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) "Palliative Treatment" means action that relieves pain but is not curative. Palliative Treatment is an all inclusive service. No other codes are billable on the same date of service.
 - (3) "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) "Upcoding" means reporting a more complex and/or higher cost procedure than actually performed.
 - (5) "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.

(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. Panoramic films are only compensable when chart documentation clearly indicates the test is being performed to rule out or evaluate non-caries related pathology.

(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 CAOHC containing material must be used.

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

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

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

(T) **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 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 317:30-5-696(a)(3)(E);

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

(vi) Dental prophylaxis as defined in 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 compensable 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.

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(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) 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) 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) 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.