Disclaimer

This information is current as of Sept. 2019

All information is subject to change. Stay up-to-date by signing up for Web Alerts at www.okhca.org
Class Description

• **Target Audience** – Dentists, Orthodontists and Administrative Staff

• **Class Description** – A current look of covered dental services, covered populations, how to submit a dental prior authorization and dental claim on the SoonerCare Provider Portal
Agenda

• Covered Services
• Eligibility
• Create a Dental Prior Authorization
• View Authorization Status/PA Notices
• Dental Claim Submission
• Resources
Covered Services
Covered Services

• SoonerCare (Oklahoma Medicaid) pays for preventative, diagnostic and restorative services for eligible members under the age of 21
• Dental care for adults residing in private Intermediate Care facilities for Individuals with Intellectual Disabilities (ICF/IID), is similar to the scope of services available to individuals under age 21
Adult Dental Coverage Limits

- Emergency extractions for ages 21 years and older
  - Tooth extraction must have medical need documented
- Limited oral examinations and medically necessary images, as defined in OAC 317:30-5-695, associated with the emergency extraction or with a clinical presentation with reasonable expectation that an emergency extraction will be needed
- Smoking and tobacco use cessation counseling
Additional Adult Coverage Limits (Organ Transplant)

Limited dental services are available for members ages 21 years and older who meet all medical criteria, but need dental clearance to obtain organ transplant approval: 371:30-5-696 (C)

- Comprehensive oral evaluation
- Two image bitewings
- Prophylaxis
- Fluoride application
- Limited restorative procedures
- Periodontal scaling/root planing
Services for Waiver Members with Developmental Disabilities

• Dental benefits for adult SoonerCare members served through the In-Home Supports Waiver or Community Waiver have been expanded.

• Adults with developmental disabilities served in these waivers are evaluated by their case managers for initial services such as general exam, cleaning and x-rays.

• Requests for additional treatment may now be directed to the case manager to include up to $1,000 in services such as fillings and root canals in the plan of care year.
Services for Waiver Members with Developmental Disabilities, cont.

- All services must be prior authorized by the member’s case manager
- The Oklahoma Department of Human Services Developmental Disabilities Services Division (OKDHS/DDSD) has prepared information packets about the expanded benefits to distribute to interested dental providers
- Packets are available upon request from the local DDSD nurse at the DHS state office
Services Covered Without A Prior Authorization (PA)
Services Covered Without PA

• Comprehensive/Periodic/Limited Oral Evaluations
• Images
• Dental Sealants
• Prophylaxis
• Fluoride/Fluoride Varnish
• Stainless Steel Crowns for Primary and Permanent Teeth
• Pulpotomies and Pulpectomies
• Anterior endodontics (2 allowed without PA)
Services Covered Without PA, cont.

- Space Maintainers
- Analgesia
- Pulp Caps
- Protective Restorations
- Smoking and Tobacco Use Cessation Counseling
- Diagnostic Casts and Oral/Facial Images
- Silver Diamine Fluoride
Silver Diamine Fluoride D1354

To limit abuse, the following administrative rules are in place (subject to change)

- For a child unable to receive restorative services in the typical office environment
- Not have any non-carious structure removed
- Not receive any other permanent restorative treatment for three months following an application
Silver Diamine Fluoride D1354, cont.

- Reimbursement for extraction of a tooth treated with SDF will not be allowed for three months following an application.
- Reimbursement is available once every 184 days for two occurrences per tooth in a lifetime.
- Reimbursement will be equal to that of a sealant.
- Limited to eight teeth per series.
Services Requiring A Prior Authorization (PA)
Services Requiring a PA

- Endodontics
- Crowns for permanent teeth
- Dentures
- Cast frame partial dentures
- Acrylic partial dentures
- Occlusal guards
- Bridges
- Periodontal scaling and root planing
- Carries risk assessment
Caries Risk Assessment

• All signatures and boxes must be completed
• The carries risk code submitted for payment must reflect the findings on the completed form
• The assessment may be reimbursed once per member per 12 months
• Submission of the OHCA Carries Risk Assessment form is now required, in addition to the DEN-2 form, when referring SoonerCare members for orthodontic treatment
Required Documents

Minimum required records to be submitted with each dental Prior Authorization Request (PARs)

- Comprehensive treatment plan
- Right and left mounted bitewing x-rays or panoramic x-ray
- Periapical films of tooth/teeth involved or the edentulous areas if not visible in the bitewings
- Six point periodontal charting
- Records on member’s oral hygiene and flossing ability
Required Documents, cont.

- X-rays and/or images must be identified by the tooth number and include date of exposure, member name, member ID, provider name and provider ID
- All x-rays or images, regardless of the media, must be submitted together with a completed and signed comprehensive treatment plan that details all needed treatment at the time of examination
- The film/print must also clearly identify the requested service
- Records will not be returned
Orthodontic Prior Authorizations (Required Documents)

• Carries Risk Assessment
• DEN-2 referral form
• DEN-6 HLLD form (score sheet)
• 3D model images of study models (images preferred)
• Panoramic x-ray
• Cephalometric x-rays with tracing
• Intraoral photographs
• Detailed description of any oral maxillofacial anomaly
• Estimated length of treatment
Orthodontic Prior Authorizations (Required Documents), cont.

- 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
- Please note that study models, film, digital media or printouts must be of sufficient quality to clearly demonstrate for the reviewer the pathology which is the basis for the minor orthodontics (appliances) requested
Provider Portal
Welcome Health Care Professional!

We are committed to making it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to payment history and the ability to search for helpful information under the Resources menu.
Eligibility, cont.

Oklahoma Health Care Authority

Eligibility Verification

Eligibility Verification Request

* Indicates a required field.
Enter the patient information. If neither Member ID nor Case Number is known, enter SSN and Date of Birth or Name and Date of Birth.

- **Member ID**: B99999999
- **Case Number**: 
- **First Name**: 
- **Last Name**: 
- **SSN**: 
- **Date of Birth**: 
- **From Date of Service**: 07/26/2019
- **To Date of Service**: 07/26/2019

- **Submit**
- **Reset**
Eligibility, *cont.*

### Coverage Details for Member

Effective/End dates are shown only for the period of time requested.

**Verification Number** 19207RDQDF - 7/26/2019 - Status: A

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SoonerCare Choice</td>
<td></td>
<td>07/26/2019</td>
<td>07/26/2019</td>
</tr>
<tr>
<td>Non Emergency Transportation</td>
<td></td>
<td>07/26/2019</td>
<td>07/26/2019</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td></td>
<td>07/26/2019</td>
<td>07/26/2019</td>
</tr>
<tr>
<td>Title 19</td>
<td></td>
<td>07/26/2019</td>
<td>07/26/2019</td>
</tr>
</tbody>
</table>

### Managed Care Information

- EPSDT
- TPL
Display Member ID Card

This card does not guarantee coverage. Copay may apply.

- Member Name:
- Member ID
- Member DOB
- Date Issued

For emergencies, call 911 or your local rescue unit.

This card does not guarantee coverage. Visit our websites or call our toll-free numbers to verify benefits, view claims or find a provider:

- SoonerCare™ [www.okhca.org](http://www.okhca.org) 1-800-987-7767
- TDD Line (Hearing Impaired) 711
- TDD Line (Hearing Impaired) 711

Provider EVS: (405) 840-0650 or 1-800-767-3949
Other inquiries: (405) 522-6205 or 1-800-522-0114

1 800 QUIT NOW
Free help: 784-8689

Oklahoma Tobacco Helpline
Add Third Party Liability (TPL)

**Coverage Details for Member ID**

Effective/End dates are shown only for the period of time requested.

**Verification Number** 19207RDQDF - 7/26/2019 - Status: A

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SoonerCare Choice</td>
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<td>07/26/2019</td>
<td>07/26/2019</td>
</tr>
<tr>
<td>Non Emergency Transportation</td>
<td></td>
<td>07/26/2019</td>
<td>07/26/2019</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td></td>
<td>07/26/2019</td>
<td>07/26/2019</td>
</tr>
<tr>
<td>Title 19</td>
<td></td>
<td>07/26/2019</td>
<td>07/26/2019</td>
</tr>
</tbody>
</table>

**Managed Care Information**

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Phone</th>
<th>Health Plan Name</th>
<th>Health Plan Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EPSDT**

<table>
<thead>
<tr>
<th>Service</th>
<th>Last Exam</th>
<th>Next Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td></td>
<td>07/17/2020</td>
</tr>
</tbody>
</table>

**TPL**

Click '+' to add a row.

<table>
<thead>
<tr>
<th>Carrier Name (Carrier ID)</th>
<th>Policy Number</th>
<th>Group ID (Employer ID)</th>
<th>Policy Holder (Relationship)</th>
<th>Policy Type</th>
<th>Coverage Type</th>
<th>Rx-BIN</th>
<th>Rx-PCN</th>
<th>Effective</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[Click to expand]
Add TPL, cont.

<table>
<thead>
<tr>
<th>Carrier Name (Carrier ID)</th>
<th>Policy Number</th>
<th>Group ID (Employer ID)</th>
<th>Policy Holder (Relationship)</th>
<th>Policy Type</th>
<th>Coverage Type</th>
<th>Rx-BIN</th>
<th>Rx-PCN</th>
<th>Effective</th>
<th>End</th>
</tr>
</thead>
</table>

* Indicates a required field.

- **Carrier Name**
- **Policy Number**
- **Policy Holder**
  - Person
  - Organization
- **Policy Holder Last Name**
- **Policy Type**
- **Coverage Type**
- **Relationship**
- **Effective**
- **Rx-BIN**

- **Carrier ID**
- **Group ID**
- **First Name**
  - MI
- **Employer ID**
- **End**
- **Rx-PCN**

[Add]  [Reset]
## Treatment History, cont.

### Search Treatment History

* Indicates a required field.

This search feature retrieves PAID claim records for a particular member ID as of the timeframe submitted.

Enter the member ID, date of service, and procedure code or tooth number, then click **Search**. Click **Reset** to clear all fields.

#### Member Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Member ID</em></td>
<td></td>
<td></td>
<td>07/17/2000</td>
</tr>
</tbody>
</table>

#### Service Information

Either Procedure Code or Tooth Number is required.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Tooth Number</th>
<th><em>Date of Service</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Any Tooth</td>
<td>Past 1 Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Past 2 Years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Past 3 Years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Past 5 Years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lifetime</td>
</tr>
</tbody>
</table>
Lifetime Disclaimer

Search Treatment History

* Indicates a required field.

This search feature retrieves PAID claim records for a particular member ID as of the timeframe submitted.

Enter the member ID, date of service, and procedure code or tooth number, then click Search. Click Reset to clear all fields.

Member Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>07/17/2000</td>
</tr>
</tbody>
</table>

Service Information

Either Procedure Code or Tooth Number is required.

Procedure Code

Tooth Number

Date of Service

*Results will show services that are only compensable once per lifetime
# Dental History Results

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Procedure Code</th>
<th>Tooth Number</th>
<th>Oral Cavity Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/18/2018</td>
<td>D0120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D1110</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D1206</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D9230</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D2150</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D2140</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D7111</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>10/02/2018</td>
<td>D9230</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/02/2018</td>
<td>D2150</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>10/02/2018</td>
<td>D2140</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>09/25/2018</td>
<td>D0140</td>
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<td></td>
</tr>
<tr>
<td>09/25/2018</td>
<td>D0220</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

Click on blue hyperlink to show more details.
# Dental History Details

**Member Information**
- **Member ID**: 999999999A
- **Birth Date**: 999999999A
- **Address**: 4345 N Lincoln Blvd
- **City**: 999999999A
- **State**: Oklahoma
- **Zip Code**: 999999999A
- **Name**: Mickey Mouse
- **Phone**: 555-555-5555

**Rendering Provider Information**
- **Rendering Provider ID**: 999999999A
- **ID Type**: NPI
- **NPI**: 999999999A

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Procedure Code</th>
<th>Tooth Number</th>
<th>Oral Cavity Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/18/2018</td>
<td>D0120</td>
<td></td>
<td>NotSpecified</td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D1110</td>
<td></td>
<td>NotSpecified</td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D2140</td>
<td>31-LOWER RIGHT SECOND MOLAR</td>
<td>NotSpecified</td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D2150</td>
<td>2-UPPER RIGHT SECOND MOLAR</td>
<td>NotSpecified</td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D9230</td>
<td></td>
<td>NotSpecified</td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D7111</td>
<td>R-LOWER RIGHT PRIMARY CANINE - CUSPID</td>
<td>NotSpecified</td>
</tr>
<tr>
<td>10/18/2018</td>
<td>D1206</td>
<td></td>
<td>NotSpecified</td>
</tr>
</tbody>
</table>
Prior Authorization

- Approved
- Disapproved
Create Prior Authorization
Create Prior Authorization, cont.

Create Authorization

* Indicates a required field.

- Medical
- Dental

When you submit this PA, you are certifying that the PA is medically necessary and correctly submitted in accordance with SoonerCare rules and is for a SoonerCare covered device or service. You acknowledge that this PA may be subject to a post-payment review and/or that OHCA may recoup improper payments if OHCA finds that this PA was inappropriately submitted or OHCA has determined the PA to be medically unnecessary. You also acknowledge that approval of this PA does not guarantee payment.

Requesting Provider Information

This panel contains provider information.

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>ID Type</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zip Code</td>
<td>Taxonomy</td>
<td>SC Provider Number</td>
</tr>
<tr>
<td>Contract Code</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Member Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

<table>
<thead>
<tr>
<th>*Member ID</th>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Birth Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Oklahoma Healthcare Authority

4345 N Lincoln Blvd, OKC | 405-522-7300 | okhca.org
**Create Prior Authorization, cont.**

This panel contains provider information.

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>NPI</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>999999999A</td>
<td>Mickey Mouse</td>
<td></td>
</tr>
</tbody>
</table>

**Member Information**

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

**Attachments**

- **Transmission Method**
  - BM-By Mail
  - FI-Electronic Only

**Other Information**

Assignment Code must be selected from the dropdown. The Assignment Code can be viewed in the Prospective Authorizations results panel and in the Search Results panel when using Search Authorizations.

**Diagnosis Information**

- **Fund**
  - [ ]

**Notes**

- [x]
Create Prior Authorization, cont.

### Diagnosis Information

Click the **Remove** link to remove the entire row.

<table>
<thead>
<tr>
<th>ICD Version</th>
<th>Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
</table>

*ICD Version: ICD-10-CM*

*Diagnosis Code:*

---

**You have reached the maximum number of rows allowed for this list.**
Create Prior Authorization, cont.

Continue entering services up to a maximum of 12 line items then submit.
Create Prior Authorization, *cont.*

**Confirm Authorization**

Click Confirm to submit authorization. Click Back to change data entered.

- Medical
- Dental

When you submit this PA, you are certifying that the PA is medically necessary and correctly submitted in accordance with SoonerCare rules and is for a SoonerCare covered device or service. You acknowledge that this PA may be subject to a post-payment review and/or that OHCA may recoup improper payments if OHCA finds that this PA was inappropriately submitted or OHCA has determined the PA to be medically unnecessary. You also acknowledge that approval of this PA does not guarantee payment.

**Requesting Provider Information**

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Contract Code</th>
<th>ID Type</th>
<th>Taxonomy</th>
<th>Name</th>
<th>SC Provider Number</th>
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</thead>
</table>

**Member Information**

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Birth Date</th>
<th>Member</th>
</tr>
</thead>
</table>

**Attachments**

No Attachments exist for this Prior Authorization

**Other Information**

<table>
<thead>
<tr>
<th>Assignment Code</th>
<th>Managed Care</th>
<th>Letter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENTAL-GENERAL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Diagnosis Information**

<table>
<thead>
<tr>
<th>ICD Version</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10-CM</td>
<td>K027-DENTAL ROOT CARIES</td>
</tr>
</tbody>
</table>

**Service Details**

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Code</th>
<th>Modifiers</th>
<th>Tooth Number</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/26/2019</td>
<td>07/26/2019</td>
<td>D3330-END THXPY, MOLAR TOOTH</td>
<td>3-UPPER RIGHT FIRST MOLAR</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

[Confirm]  [Cancel]
Authorization Receipt

Your Prior Authorization Number 5819999999 was successfully submitted.

Click Attachment Coversheet to view the authorization attachments coversheet.
Click Print Preview to view authorization details and receipt.
Click Copy to copy member data or authorization data.
Click New to create a new authorization for a different member.

Attachment coversheet box will only appear if you chose “By Mail” attachments.
View Prior Authorization Status
View Authorization Status
Search Authorizations

View Authorization Status

Prospective Authorizations  Search Authorizations  Authorization Notices

Enter at least one of the following fields to search for an authorization. For Advanced search PA or Member ID/day range is required.

Authorization Information

Advanced Search □
Prior Authorization Number
Assignment Code
Code Type □
Code □
Select a Day Range or specify a Service Date. The optional date criterion provides a search option based on the Authorized Effective and Authorized End Date of the Prior Authorization.
Authorized Day Range □ OR Authorized Service Date □

Member Information

Member ID B99999999

Provider Information

Provider NPI
This Provider is the □ Servicing Provider on the Authorization □ Referring Provider on the Authorization

Search Results

The Search criteria selected in the Search Authorizations panel reflect the Search Results displayed.

Total Records: 1

<table>
<thead>
<tr>
<th>Prior Authorization Number</th>
<th>Authorized Service Date □</th>
<th>Member Name</th>
<th>Member ID</th>
<th>Assignment Code</th>
<th>Requesting Provider</th>
<th>Servicing Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>5819999999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Export results...
## Authorization Details

### Line | Authorized From Date | Authorized To Date | Requested From Date | Requested To Date | Units | Units Used | Dollars | Dollars Used | Code | Remarks | Status
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
A | - | - | 03/01/2019 | 06/01/2019 | 0 | 0 | - | - | D4342-PERIODONTAL SCALING 1-3TEETH | View | System Cancelled
B | 03/01/2019 | 06/01/2019 | 03/01/2019 | 06/01/2019 | 1 | 0 | - | - | D4342-PERIODONTAL SCALING 1-3TEETH | View | Pending
C | 03/01/2019 | 06/01/2019 | 03/01/2019 | 06/01/2019 | 1 | 0 | - | - | D4342-PERIODONTAL SCALING 1-3TEETH | View | Evaluation
D | 03/01/2019 | 06/01/2019 | 03/01/2019 | 06/01/2019 | 1 | 0 | - | - | D4342-PERIODONTAL SCALING 1-3TEETH | View | Pending

**Payment Method**: 1-Pay System Calculated Price

**Reason**
- A: 252-Quadrant is required but not listed on PA; or quad is not valid for this procedure.
- B: 412-Under Review by Dental Analyst
- C: 411-Under Review by Dental Admin Assistant
- D: 068-Request pended for additional documentation.

---

**Click on blue hyperlinks to obtain more information**

**View the status of each line item**
Authorization Details, cont.

<table>
<thead>
<tr>
<th>D</th>
<th>03/01/2019</th>
<th>06/01/2019</th>
<th>03/01/2019</th>
<th>06/01/2019</th>
<th>1</th>
<th>0</th>
<th>-</th>
<th>-</th>
<th><strong>D4342-PERIODONTAL SCALING 1-3 TEETH</strong></th>
<th>Pending Documents</th>
</tr>
</thead>
</table>

**Payment Method** 1-Pay System Calculated Price

**Reason**
068-Request pended for additional documentation.

**Remarks**
1 3/14/2019 quad - will be required
2 3/14/2019 quad - will be required
3 3/14/2019 quad - will be required
4 3/14/2019 quad - will be required
5 3/14/2019 quad - will be required
6 8/16/2019 Send Perio chart

---

**Dental Information**

<table>
<thead>
<tr>
<th>Tooth No.</th>
<th>Oral Cavity Area</th>
<th>20-UPPER LEFT QUADRANT</th>
</tr>
</thead>
</table>

---

**Payment Method** 1-Pay System Calculated Price

**Reason**
411-Under Review by Dental Admin Assistant

---

Click to attach pending documents

View Original Request
Attach Pending Documents, cont.

Informational
The request has been submitted successfully

---

### Authorization Request

- **Medical**
- **Dental**

When you submit this PA, you are certifying that the PA is medically necessary and correctly submitted in accordance with SoonerCare rules and is for a SoonerCare covered device or service. You acknowledge that this PA may be subject to a post-payment review and/or that OHCA may recoup improper payments if OHCA finds that this PA was inappropriately submitted or OHCA has determined the PA to be medically unnecessary. You also acknowledge that approval of this PA does not guarantee payment.

### Requesting Provider Information

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Zip Code</th>
<th>Contract Code</th>
<th>ID Type</th>
<th>NPI</th>
<th>Name</th>
<th>SC Provider Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>73107-1902</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Member Information

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Attachments

<table>
<thead>
<tr>
<th>Transmission Method</th>
<th>File</th>
<th>Control #</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1/E - Electronic Only</td>
<td>HCA-13D Updated.pdf</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B - By Mail</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Transmission Method
*Upload File
*Description

---

### Other Information

<table>
<thead>
<tr>
<th>Assignment Code</th>
<th>Managed Care</th>
<th>Managed Care Letter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>DENTAL-GENERAL</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

4345 N Lincoln Blvd, OKC | 405-522-7300 | okhca.org |
**Attach Pending Documents, cont.**

**Diagnosis Information**

No Diagnosis Codes exist for this authorization

**Service Details**

<table>
<thead>
<tr>
<th>From Date</th>
<th>To Date</th>
<th>Code</th>
<th>Modifiers</th>
<th>Tooth Number</th>
<th>Units</th>
<th>Cancel</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/01/2019</td>
<td>06/01/2019</td>
<td>D4342-PERIODONTAL SCALING 1-3TEETH</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>03/01/2019</td>
<td>06/01/2019</td>
<td>D4342-PERIODONTAL SCALING 1-3TEETH</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>03/01/2019</td>
<td>06/01/2019</td>
<td>D4342-PERIODONTAL SCALING 1-3TEETH</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>03/01/2019</td>
<td>06/01/2019</td>
<td>D4342-PERIODONTAL SCALING 1-3TEETH</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>03/01/2019</td>
<td>06/01/2019</td>
<td>D4342-PERIODONTAL SCALING 1-3TEETH</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Error**

There were no PA line items to be cancelled and/or additional documents to be uploaded. Please try again.

Do not hit submit again or you will receive an error message, do not panic we did receive your documents.
Advanced search allows you to view prior authorizations for the member from other dental providers. Certain criteria is required to view the authorizations.

**Advanced Search**

- **Prospective Authorizations**
- **Search Authorizations**
- **Authorization Notices**

Enter at least one of the following fields to search for an authorization.

For Advanced search PA or Member ID/day range is required.

**Authorization Information**

- **Advanced Search**
  - Medical
  - Dental
  - Both
- **Prior Authorization Number**
  - **Authorized Day Range**
- **Service Code**
- **Code Type**
- **Authorized Service Date**

Select a Day Range or specify a Service Date. The optional date criterion provides a search option based on the Authorized Effective and Authorized End Date of the Prior Authorization.

**Member Information**

- **Member ID**

**Provider Information**

- **Provider NPI**
- **This Provider is the**
  - Servicing Provider on the Authorization
  - Referring Provider on the Authorization

- **Search**
- **Reset**
Authorization Notices, cont.
# Search Results

The Search criteria selected in the Authorization Notices panel reflect the Search Results displayed. To access the Authorization Notice, select a 'Date Sent' link. Access to an Authorization Notice will require a file viewer. If the Authorization Notice is too large to display, you will need to contact Provider Services for assistance.

**Total Records: 64**

<table>
<thead>
<tr>
<th>Prior Authorization Number</th>
<th>Date Sent</th>
<th>Member</th>
<th>Requesting Provider</th>
<th>Servicing Provider</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>5819999999</td>
<td>07/08/2019</td>
<td>Suzi SoonerCare</td>
<td>Mickey Mouse</td>
<td></td>
<td>Unread</td>
</tr>
<tr>
<td>5819899999</td>
<td>07/08/2019</td>
<td>Daffy Duck</td>
<td>Mickey Mouse</td>
<td></td>
<td>Unread</td>
</tr>
<tr>
<td>5819899998</td>
<td>06/26/2019</td>
<td>Donald Duck</td>
<td>Mickey Mouse</td>
<td></td>
<td>Unread</td>
</tr>
</tbody>
</table>

- Click on Prior Authorization Number to view authorization details
- Click on Date Sent to change the status from Unread to Read
Dental Claim Submission
Submit Dental Claim

- Submit Claim Dental
- Search Claims
- Submit Claim Inst
- Submit Claim Prof
- Submit Claim Pharm
- Search Payment History
Choose None if there is no other insurance for the member.
Submit Dental Claim, cont.

Choose Include if there is a payment from primary insurance – no EOB needs to be attached
**Submit Dental Claim, cont.**

Enter amount of payment from primary insurance

<table>
<thead>
<tr>
<th>Provider Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Billing Provider ID</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Zip Code</strong></td>
<td></td>
</tr>
<tr>
<td><strong>ID Type</strong></td>
<td><strong>NPI</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient and Claim Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member ID</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Birth Date</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td><strong>Male</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other Insurance Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TPL Amount</strong></td>
<td></td>
</tr>
</tbody>
</table>

[Continue] [Cancel] [Back to Step 1]
Submit Dental Claim, *cont.*

Choose denied if primary denied the claim or paid $0.00 – EOB must be attached.
Submit Dental Claim, cont.

### Submit Dental Claim: Step 2

* Indicates a required field.

#### Provider Information

<table>
<thead>
<tr>
<th>Billing Provider ID</th>
<th>ID Type</th>
<th>NPI</th>
<th>SC Provider Numbe.</th>
</tr>
</thead>
</table>

#### Patient and Claim Information

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Member</th>
<th>Birth Date</th>
<th>Gender</th>
<th>Total Charged Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

#### Diagnosis Codes

Diagnosis Code is Optional. If a diagnosis is included, both the ICD Version and the Diagnosis Code need to be entered. Select the row number to edit the row. Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>ICD Version</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ICD-10-CM</td>
<td></td>
</tr>
</tbody>
</table>

[Add] [Reset]

[Continue] [Cancel]
Submit Dental Claim, cont.

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>05/22/2019</td>
<td></td>
<td>31-LOWER RIGHT SECOND MOLAR</td>
<td>D3330-EN THXPY, MOLAR</td>
<td></td>
<td>500.00</td>
<td></td>
</tr>
</tbody>
</table>

- **Svc Date**: 05/22/2019
- **Oral Cavity Area**: 
- **Tooth Number**: 31
- **Procedure Code**: D3330-EN THXPY, MOLAR
- **Units**: 
- **Charge Amount**: 500.00
- **Rendering Provider ID**: 123456789
- **ID Type**: NPI
- **Zip Code**: 
- **SC Provider Number**: 

**Add** button highlighted.
Submit Dental Claim, cont.

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>05/22/2019</td>
<td>31-LOWER RIGHT SECOND MOLAR</td>
<td>D3330</td>
<td>1</td>
<td>$500.00</td>
<td>Remove</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>05/22/2019</td>
<td>14-UPPER LEFT FIRST MOLAR</td>
<td>D2394</td>
<td>1</td>
<td>$150.00</td>
<td>Remove</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continue to add services as needed
Add any attachments that are required - Ex: EOB then submit
## Confirm Dental Claim, cont.

**Provider Information**

<table>
<thead>
<tr>
<th>Billing Provider ID</th>
<th>ID Type</th>
<th>NPI</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Information**

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Gender</th>
<th>Male</th>
</tr>
</thead>
</table>

**Claim Information**

- **Accident Related**: 
  - Place of Treatment: 11-Office
- **Emergency**: 
  - Patient Account Number:
  - Total Charged Amount: $650.00

**Diagnosis Codes**

**Service Details**

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Tooth Surface</th>
<th>Prosthesis</th>
<th>Cavity Code</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Diag Code Ptrs</th>
<th>Units</th>
<th>Rendering Provider</th>
<th>Co-pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>05/22/2019</td>
<td></td>
<td>31</td>
<td></td>
<td></td>
<td>D3330</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>05/22/2019</td>
<td></td>
<td>14</td>
<td>M-MESIAL P-FACIAL</td>
<td>D2394</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**No Other Insurance Details exist for this claim**
**No Attachments exist for this claim**

[Confirm] [Cancel]
Your Dental Claim was successfully submitted. The claim status is Paid.
The Claim ID is 2219999999999
# View Dental Claim

## Provider Information
- Billing Provider ID
- Zip Code
- ID Type
- NPI
- Name
- SC Provider Number

## Patient Information
- Member ID
- Membership
- Birth Date
- Gender: Male

## Claim Information
- Claim Status: Paid
- Accident Related: No
- Place of Treatment: Office
- Related Claim: No
- Emergency: No
- Patient Account Number
- Total Charged Amount: $650.00
- Total Co-pay Amount: $0.00
- Total Allowed Amount: $125.69
- Total Paid Amount: $125.69

## Adjudication Errors

## Service Details

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Tooth Surface</th>
<th>Prosthesis</th>
<th>Cavity Code</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Diag Code</th>
<th>Units</th>
<th>Rendering Provider</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>05/22/2019</td>
<td>31</td>
<td></td>
<td></td>
<td>D3330</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$500.00</td>
<td></td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2</td>
<td>05/22/2019</td>
<td>14</td>
<td>M-MESIAL</td>
<td>F-FACIAL</td>
<td>D-DISTAL</td>
<td>L-LINGUAL</td>
<td>O-OCCLUSAL</td>
<td>1</td>
<td></td>
<td></td>
<td>$150.00</td>
<td>$125.69</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

No Other Insurance Details exist for this claim.

No Attachments exist for this claim.
Resources

WE CAN HELP
Resources

• Dental Prior Authorization
  405-522-7401
• OHCA Provider Helpline
  800-522-0114, option 1
• Internet Help Desk
  800-522-0114, option 2,1
• OHCA public website

www.okhca.org
Resources

• Dental Provider Page
  www.okhca.org/dental-providers

• Dental Newsletter
  www.okhca.org/dental-news

• Dental page for members
  www.okhca.org/memberdental
Training Resources

For onsite training requests, contact the SoonerCare Education team.

SoonerCareEducation@okhca.org
Phone: 405-522-7422
Fax: 405-530-3288

* Please include the provider’s name, SoonerCare ID number, a return phone number and a contact name with the request.
Questions?