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1.0 Description of the Procedure, Product, or Services

Orthodontics is defined as a corrective procedure for functionally impairing occlusal conditions. Such services shall maintain a high standard of quality and shall be within the reasonable limits of those that are customarily available and provided to most persons in the community with the limitations and exclusions hereinafter specified. **Only the procedure codes listed in this policy are covered under the North Carolina Medicaid Dental Program.**

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2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for dental services as described in this policy. The recipient must be eligible for dental services on the date that treatment is rendered in order for Medicaid to pay the claim.

2.2 Limitations

Pregnant Medicaid-eligible recipients covered under the Medicaid for Pregnant Women program class "MPW" and recipients covered under the Family Planning Waiver program class "MAFD" are not eligible for orthodontic services as described in this policy. Recipients covered under the Medicare Qualified Beneficiaries program class "MQB" do not receive a Medicaid card and the only benefit that the recipient receives from Medicaid is the payment of the Medicare premium only. The recipient is not eligible for any orthodontic services as described in this policy. Recipients enrolled with the Program of All-Inclusive Care for the Elderly (PACE) are not covered for orthodontic services as described in this manual. Providers should ask recipients for their PACE card and contact the PACE program for information regarding benefits. Refer to **Subsection 5.3, Procedure Codes and Limitations for Orthodontics** for eligibility limitations for individual procedure codes.

2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

3.0 When the Procedure, Product, or Service is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs,
- b. the procedure, product, or service can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide, and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

d. 3.2 Specific Criteria

The following criteria for functionally impairing occlusal conditions apply when cases are reviewed for N.C. Medicaid orthodontic approval. The probability for approval is increased when **two or more** of the following criteria exist:

- a. Severe skeletal condition that may require a combination of orthodontic treatment and orthognathic surgery to correct (recipient's age and the direction of growth are also considered).
- b. Severe anterior-posterior occlusal discrepancy (Class II or Class III dental malocclusion).
- c. Posterior transverse discrepancies that involve several posterior teeth in crossbite, one of which must be a molar (crossbite must demonstrate functional shift).
- d. Anterior crossbite that involves more than two teeth.
- e. True anterior openbite (excessive 4 mm or greater and does not include one or two teeth slightly out of occlusion or where the incisors have not fully erupted and not correctable by habit therapy).
- f. Significant posterior openbite (not involving partially erupted teeth or one or two teeth slightly out of occlusion).
- g. Overbite must be deep, complete, and traumatic (a majority of the lower incisors must be causing palatal tissue trauma).
- h. Overjet (excessive protrusion 6 mm or greater).
- i. Crowding greater than 6 mm in either arch that must be moderate to severe and functionally intolerable over a long period of time (such as occlusal disharmony and/or gingival recession secondary to severe crowding).
- j. Impactions with a good prognosis of being brought into occlusion.
- k. Excessive anterior spacing of 8 mm or greater from mesial of cuspid to mesial of cuspid.
- l. Occlusal condition that exhibits a profound impact from a congenital or developmental disorder or severe, traumatic incident.
- m. Psychological and emotional factors causing psychosocial inhibition to the normal pursuits of life (requires supporting documentation of pre-existing condition from a licensed mental health professional specializing in child psychology or child psychiatry).
- n. Potential that all problems will worsen.

4.0 When the Procedure, Product, or Service is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care** services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible,

compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in Section 2.0,
- b. the recipient does not meet the medical necessity criteria listed in Section 3.0,
- c. the procedure, product, or service duplicates another provider's procedure, or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Orthodontic services are not covered when the above medical criteria are not met. Additionally, the following types of cases are not eligible for approval:

- a. Interceptive or Phase I treatment cases of the primary and transitional dentition except for cases involving functionally impairing malocclusions caused by cleft lip/palate or other severe craniofacial developmental anomalies or severe traumatic injuries.
- b. Minor tooth movement cases requiring a relatively short treatment period (less than twelve months).
- c. Cuspid impactions with a poor prognosis of being brought down into occlusion in the presence of no other significant problems.
- d. Bilateral or unilateral posterior crossbites of moderate severity without a significant mandibular shift or history of temporomandibular dysfunction and a lack of other significant problems.
- e. Class I malocclusions with moderate crowding, no crossbites, overbite and overjet within normal limits.
- f. Simple space closure of mild to moderate anterior spacing.
- g. Simple one arch treatment.
- h. Localized tooth alignment problems requiring a relatively short period of treatment (such as simple anterior or posterior crossbites, diastema closure, rotations, etc.).
- i. Orthodontic treatment begun prior to the patient becoming eligible for Medicaid
- j. Habit appliance therapy.
- k. Occlusal guard/splint therapy (including splint therapy for the treatment of temporomandibular dysfunction).
- l. Orthodontic treatment started as a private pay arrangement before Medicaid approval is requested and/or granted.

If a non-covered orthodontic service is deemed medically necessary and warrants consideration of approval, the provider should submit a prior approval request along with a letter describing the special circumstances of the case and appropriate orthodontic records. (Refer to **Subsection 5.9, Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations**, for specific instructions on submitting a prior approval request.)

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care** services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

5.1 Prior Approval for Orthodontics Services

Orthodontic services require prior approval. The orthodontic records must be obtained for each case and screened to determine that the case is functionally impairing. All radiographs, models, and other parts of the orthodontic records must be of acceptable diagnostic quality or the case will be returned. All orthodontic prior approval information (ADA claim forms, pretreatment narrative, radiographs, and models) must be received in the same package for each recipient. Multiple cases can be sent in the same package. If all the information is not received in the same package, the case will be returned to the provider requesting the additional information.

Refer to Attachment A – Orthodontic Billing Guide, for additional information.

5.2 ADA-Approved Materials

Only dental materials accepted by the ADA Council on Dental Therapeutics are accepted for use in the dental care of Medicaid recipients. Specific use of these materials must follow the ADA Council on Dental Therapeutics guidelines.

5.3 Procedure Codes and Limitations for Orthodontics

By State legislative authority, DMA applies service limitations to ADA procedure codes as they relate to individual recipients. These service limitations are applied without modification of the ADA procedure description. Limitations that apply to an entire category of service are described at the beginning of the appropriate subsection. Limitations that apply to an individual procedure code are indicated by an asterisk (*) beneath the description of that code. Claims for services that fall outside these limitations will be denied unless special approval is granted for services deemed medically necessary for a Medicaid recipient under age 21. Refer to **Subsection 5.9, Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations.**

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5.3.1 Comprehensive Orthodontic Treatment

Medicaid approval and reimbursement for comprehensive orthodontic treatment also includes any fixed or removable appliances necessary to complete the approved treatment including-palatal expanders, bite plates, holding arches, and/or retainers, etc.

Code	Description	PA Needed?
D8070	<p>Comprehensive orthodontic treatment of the transitional dentition</p> <ul style="list-style-type: none"> * limited to recipients under age 21 * limited to functionally impairing malocclusions caused by cleft lip/palate or other severe craniofacial developmental anomalies or traumatic injuries which effect the function of speech, chewing, and/or swallowing * includes placement of fixed or removable appliances (such as an activator) necessary to initiate active treatment * once in a lifetime service unless special approval is granted for services deemed medically necessary for a Medicaid recipient under age 21 	Yes
D8080	<p>Comprehensive orthodontic treatment of the adolescent dentition</p> <ul style="list-style-type: none"> * limited to recipients under age 21 * use for full banding including the placement of upper and lower arch bands, brackets, and appliances necessary to initiate active treatment * limited to functionally impairing malocclusions * once in a lifetime service unless special approval is granted for services deemed medically necessary for a Medicaid recipient under age 21 	Yes
D8670	<p>Periodic orthodontic treatment visit (as part of contract)</p> <ul style="list-style-type: none"> * limited to recipients under age 21 * use for monthly maintenance visit * allowed once per calendar month * limited to functionally impairing malocclusions * not allowed for repair or replacement of broken or missing brackets, bands, or wires when no other maintenance treatment is rendered * prior approval of orthodontic services is granted for 36 months * limited to 23 reimbursable maintenance visits * the banding and 23 maintenance visits constitute the total reimbursement for comprehensive orthodontic treatment and the provider is expected to complete any additional maintenance visits necessary to achieve an acceptable treatment outcome without further reimbursement * if the case is approved and the banding is paid, Medicaid will continue to pay for monthly maintenance visits regardless of eligibility * once a case is approved, it is anticipated that all banding and monthly maintenance visits will be completed by the recipient's 21st birthday 	Yes

Code	Description	PA Needed?
D8680	<p>Orthodontic retention (removal of appliances, construction and placement of retainer(s))</p> <ul style="list-style-type: none"> * limited to recipients under age 21 * once in a lifetime service unless special approval is granted for services deemed medically necessary for a Medicaid recipient under age 21 * when comprehensive orthodontic treatment is complete and less than 23 maintenance visits were paid, submit a Post Treatment Summary and a claim form for final payment * when comprehensive orthodontic treatment is terminated, submit a Termination Request and a claim form for payment of a maintenance visit to cover the cost of debanding and/or retainers 	Yes

Note: When a case is approved for comprehensive orthodontic treatment, all fixed or removable appliances (including broken or lost brackets) necessary to complete the approved treatment are included in the Medicaid payment and the recipient must **not** be billed any additional charges.

5.4 Orthodontic Review Board

The Orthodontic Review Board will determine on a case-by-case basis whether or not to authorize coverage. If necessary, members of the review board will physically examine the recipient before approval of the case. In reaching a decision, the functional need will be examined as well as other factors such as:

- a. The recipient's attitude and ability to meet appointments.
- b. The recipient's ability to follow instructions and cooperate through a lengthy treatment period.
- c. The recipient's ability to maintain an acceptable level of oral hygiene vital to the success of treatment.

5.5 Orthodontic Records

It is essential that Medicaid eligibility be confirmed on the date of the orthodontic records. **If the recipient is not eligible, no payment will be made.**

Medicaid does not cover interceptive orthodontics. Therefore, professional judgment should be used to determine at what stage orthodontic records are taken. Orthodontic records are a once in a lifetime service. Orthodontic records are to be filed together on one two-part 2006 ADA form.

Procedure Code	Description
D0150	Comprehensive oral evaluation
D0330	Panoramic film
D0340	Cephalometric film
D0470	Diagnostic casts

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and an example of a claim for orthodontic records.

5.6 Notifications to the Provider

Once a decision is made regarding the request for orthodontic services, written notification will be sent to the provider. No additional notification will be made to the provider regarding the claim for the orthodontic records. It will be forwarded for payment processing by HP.

- a. If the case is approved, HP will return the orthodontic records and the prior approval request stamped "Approved" with the date of approval.
- b. If the case is denied, HP will return the denied prior approval form and all orthodontic records. A letter of notification of denial, along with appeal rights, will be mailed to the recipient. A copy of the denial letter will also be mailed to the provider.

5.7 Periodic Maintenance Visits

It is anticipated that the treatment period will be completed in 24 to 36 months after initial banding. Periodic maintenance visits are paid only once per calendar month with a total of 23 visits allowed.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information.

5.8 Reimbursement of Orthodontic Maintenance Visits During Ineligible Periods

It is essential that Medicaid eligibility be confirmed on the date of banding. If the recipient is not eligible, no payment will be made. Orthodontic periodic maintenance visits will be reimbursed regardless of the recipient's eligibility status at that visit **as long as the recipient was eligible on the date of banding**. The case must be approved before the initial banding takes place. Banding must occur before maintenance visits are billed.

No other services will be covered during ineligible periods. Providers should make the recipient aware that Medicaid will not pay for any routine care, restorative care, extractions, or orthognathic surgery needed during orthodontic treatment if rendered during ineligible periods.

5.9 Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations

Dental providers may request special approval for a service that is non-covered by the NC Medicaid program or falls outside the limitations stated in this policy, if that service is deemed medically necessary for a Medicaid recipient under age 21. **All such requests must be submitted in writing prior to delivery of the service.** The request must include

- a. a completed two-part 2006 ADA claim form,
- b. any materials needed to document medical necessity (such as radiographs, photographs, a letter from the recipient's medical care provider), and
- c. the completed Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age or a cover letter that documents how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes documentation about how the service, product, or procedure will correct or ameliorate (improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure.

Send requests to

**Assistant Director of Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: 919-715-7679**

If the procedure(s) receives special approval and the recipient is Medicaid-eligible on the date the service is rendered, the dentist then can file for reimbursement.

Note: A copy of the Non-Covered State Medicaid Plan Services Request Form for Recipients Under 21 Years of Age can be found on the EPSDT provider page. The Web is <http://www.ncdhhs.gov/dma/epsdt/>.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Note: All dental providers participating in the Medicaid program must provide services in accordance with the rules and regulations detailed in this policy.

7.0 Additional Requirements

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care** services to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Orthodontic Transfer Cases

The recipient must be receiving orthodontic treatment that was approved by Medicaid to be considered for continuation of treatment.

7.2.1 In-State Transfer Cases

The following information is required for approval of in-state transfer cases:

- a. A completed two-part 2006 ADA form indicating the number of remaining periodic maintenance visits.
- b. A cover letter indicating that the case is an "in-state transfer." The letter must include:
 - * the initial provider's name and address
 - * the recipient's history status
 - * the anticipated length of the remaining treatment
- c. An American Association of Orthodontics (AAO) Transfer Form or a copy of the original Medicaid orthodontic approval marked "VOID".

The cover letter and form should be sent to the HP Prior Approval Unit, Orthodontic Review Board.

Note: Providers are reminded that reimbursement for transfer cases is limited to the remaining number of periodic maintenance visits for that recipient.

7.2.2 Out-of-State Transfer Cases

The recipient must have been approved for comprehensive orthodontic treatment under the Medicaid program in their previous state of residence to be considered for continuation of treatment in North Carolina.

The following information is required for approval of out-of-state transfer cases:

- a. A completed two-part 2006 ADA form indicating the number of remaining periodic maintenance visits.
- b. Orthodontic records indicating that the case is an “out-of-state transfer.” The records must include a narrative which includes:
 - * the initial provider’s name and address
 - * the recipient’s history status
 - * the anticipated length of the remaining treatment
- c. If possible, a copy of the American Association of Orthodontics (AAO) Transfer Form or a copy of the orthodontic treatment records from the previous provider.
- d. Attach some proof of Medicaid eligibility in the previous state of residence (copy of the Medicaid card from the previous state or records from the previous provider that indicate Medicaid as the payer).

Note: Photos and models are helpful but not necessary. The records and form should be sent to the HP Prior Approval Unit, Orthodontic Review Board.

Note: Providers are reminded that reimbursement for transfer cases is limited to the remaining number of periodic maintenance visits for that recipient.

7.3 Terminated Orthodontic Treatment

Case termination prior to completion of treatment should rarely take place. All efforts should be made to complete the active phase of treatment. If the recipient does not have a telephone, they may wish to give the dentist a telephone number of someone to contact, such as a county social worker, friend, or relative.

If circumstances occur beyond control of the dentist (such as recipient death or moving out of state) that prevent orthodontic treatment completion, the provider should notify HP. The provider must submit a written treatment termination form and include supporting documentation, such as when and how attempted contacts were made (such as information indicating telephone calls made, messages left with neighbors or friends, letters, etc.).

If payment is being requested for debanding and retainers, a completed 2006 ADA claim form for procedure code D8680 (orthodontic retention) and a copy of the patient records is required to substantiate payment. If less than 6 maintenance visits were rendered, no additional reimbursement will be allowed since payment received for the banding constitutes about one-third of the maximum allowed for the entire treatment.

If the recipient was only banded, Medicaid may require that a percentage of the banding fee be refunded to the program. This will be based on individual case consideration and the circumstances surrounding case termination. In these cases, Medicaid will contact the provider to make arrangements for the refund.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and an example of the Orthodontic Treatment Termination Form.

7.4 Orthodontic Treatment Extension Request (when paid maintenance visits have not exceeded the 23 allowed)

It is anticipated that the orthodontic treatment will be completed within 36 months. When the orthodontic treatment period exceeds this 3-year period and the provider has not received payment for the 23 maintenance visits, the provider must submit a written treatment extension request. Two copies of this request are required so that HP can notify the provider once the extension period has been granted.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and an example of the Orthodontic Treatment Extension Request.

7.5 Orthodontic Case Completion

Providers are allowed payment for the banding and 23 monthly maintenance visits. Payment received for banding constitutes about one-third of the maximum allowed for the entire treatment. The balance is paid incrementally with each periodic maintenance visit. The banding and 23 maintenance visits constitute the total reimbursement for comprehensive orthodontic treatment. The provider is expected to complete any additional maintenance visits necessary to achieve an acceptable treatment outcome without further reimbursement.

In rare instances, it may take fewer than 23 visits to complete treatment. In such cases, a provider may submit a final claim for payment of the balance of remaining visits. Complete the 2006 ADA claim form for procedure code D8680 (orthodontic retention). HP will manually price the claim, based on the number of remaining visits.

If fewer than 12 maintenance visits were paid, record review is required to substantiate the final claim payment. If it is determined that treatment was not “completed” but rather “terminated,” the final payment will not be allowed.

At case completion, submit an Orthodontic Post Treatment Summary and a completed 2006 ADA claim form for procedure code D8680 (orthodontic retention). The claim will be manually priced and Medicaid will allow reimbursement based on the number of remaining visits. The post-treatment summary includes the results of the treatment and assessment of the recipient’s cooperation. It is important that Medicaid receives a post-treatment summary in order to complete case records. The final orthodontic claim will not be paid unless a post-treatment summary is also submitted.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and a copy of the Orthodontic Post Treatment Summary.

7.6 Medical Record Documentation

Providers are responsible for maintaining all financial, medical, and other records necessary to fully disclose the nature and extent of services billed to Medicaid. These records must be retained for a period of at least six (6) years from the date of service, unless a longer retention period is required by federal or state law, regulations, or agreements. The provider must furnish upon request appropriate documentation—including recipient records, supporting material, and any information regarding payments claimed by the provider—for review by DMA, its agents, the Centers for Medicare and Medicaid Services (CMS), the Medicaid Investigations Unit of the N.C. Attorney General’s Office, and other entities as required by law. Providers cannot charge for records requested by Medicaid.

The N.C. State Board of Dental Examiners applicable rule regarding patient records (21 NCAC 16T. 0101) states that a dentist shall maintain complete treatment records on all patients treated for a period of at least ten (10) years. The complete Board rule regarding patient records is available for review at <http://ncdentalboard.org/pdf/RulesRevised.pdf>.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

7.7 Transfer of Recipient Dental Records

Providers are reminded to provide records of diagnostic quality when transferring dental records to another provider or directly to a recipient. Since bitewing radiographs are allowed once a year and panoramic films and intraoral complete series are allowed once every five years, it is imperative that the films/images that are transferred are of diagnostic quality so the provider receiving the radiographs can make a proper diagnosis regarding treatment.

Rules of the North Carolina State Board of Dental Examiners state “*A dentist shall, upon request by the patient of record, provide original or copies of radiographs and a summary of the treatment record to the patient or to a licensed dentist identified by the patient. A fee may be charged for duplication of radiographs and diagnostic materials. The treatment summary and radiographs shall be provided within 30 days of the request and shall not be contingent upon current, past or future dental treatment or payment of services.*” [21 NCAC 16T.0102]

Medicaid policy does not prohibit a dentist from charging a record duplication fee to a Medicaid recipient, provided the same fee is charged to private-pay patients. Board rules do not set a maximum level for this duplication fee. When DMA or HP requests records to verify medical necessity or accuracy of billing, providers do not receive compensation.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2002

Revision Information:

Date	Section Revised	Change
10/1/2003	All Sections	Implementation of CDT-4 Procedure Codes and style/grammar revisions
10/1/2004	All Sections	Implementation of the 2002 ADA Claim Form
9/1/2005	Section 2.3; 5.3; and 5.9	A special provision related to EPSDT was added.
12/1/05	Section 2.3	The web address for DMA's EPSDT policy instructions was added to this section.
12/1/06	Section 2.3	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0; 4.0; and 5.0	A note regarding EPSDT was added to these sections.
5/1/2007	Sections 2.3; 3.0; 4.0; and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for recipients under age 21 years of age.
06/01/2007	Section 5.9	Revised to include the Non-Covered State Medicaid Plan Services Request Form (for recipients under 21 years of age).
06/01/2007	Section 1.0; 5.3; and Attachment A	Updated CDT 2006 Copyright disclaimer and revised the Orthodontic Billing Guide to include the 2006 ADA claim form.
04/01/2010	1.0; 2.2; 2.3; 5.1; 5.3; 5.7; 5.8; 5.9; 6.0; 7.3; 7.4; 7.5; 7.6; 7.7; 8.0; and Attachment A	Updated CDT 2009/2010 Copyright disclaimer; changed EDS company name to HP throughout the document; removed "pink" regarding the Medicaid for Pregnant Women Medicaid card; removed "blue" regarding the Family Planning Waiver Medicaid card; added statements regarding recipients covered under the Medicare Qualified Beneficiaries program; added statements regarding recipients covered under the Program of All-Inclusive Care for the Elderly (PACE) program; added heading for ADA-Approved Materials; added section on Medical Record Documentation; added section on Compliance; added section on Transfer of Recipient Dental Records; moved the information in Section 8 (Billing Guidelines) to Sections 5 and 7; removed Field 58 as a required field on the ADA claim form; updated orthodontic forms; made general revisions throughout the policy to improve clarity, grammar, and style; and incorporated standard statements where appropriate.

Date	Section Revised	Change
08/01/2011	1.0; 3.0; 3.1; 3.2; 4.0; 4.1; 4.2; 5.0; 5.1; 5.3, 5.3.1; 5.8; 6.0; 7.0; 7.1; 7.2, 7.2.1; 7.2.2; 7.3; 7.4; 7.5; 7.6; and Attachment A.	Updated policy to standard DMA language; changed “functionally handicapping” to “functionally impairing”; updated CDT 2011/2012 copyright disclaimer; clarification of existing criteria and included additional criteria to document covered and non-covered orthodontic treatment; addition of procedure code D8070; clarification of existing procedure codes; and clarification of orthodontic transfer cases, terminated cases, and completed cases.

Attachment A: Orthodontic Billing Guide

A1: Instructions for Requesting Orthodontic Prior Approval

Requests for Orthodontic Prior Approval

Once a case has been screened, the orthodontic records obtained, and it is certain the case is **functionally impairing**, the following steps should be taken:

- a. Complete one 2006 two-part ADA form for the orthodontic records (initial exam, panoramic film, cephalometric film, and diagnostic casts).
- b. Complete another 2006 two-part ADA form, which will serve as your request for prior approval to perform orthodontic procedure codes (banding and maintenance).

Mail both forms with the following:

- a. Properly occluded and trimmed dental models
- b. An interpreted cephalometric film
- c. A panoramic film or full series of intraoral films
- d. Intraoral and facial photographs (optional but not reimbursed by Medicaid)
- e. A written narrative which includes:
 - * the provider's assessment of the recipient's motivation, ability to cooperate for orthodontic care, and ability to maintain oral hygiene
 - * the provider's assessment of the recipient's oral condition and the need for treatment
 - * the provider's assessment of the recipient's history of compliance with previous dental care
 - * the estimated fee for the orthodontic treatment
 - * the estimated treatment period
 - * the proposed treatment plan (such as reduce overjet, extract premolars, extract supernumerary teeth, expose impacted teeth, remove cysts, restorations, orthognathic surgery, etc.)
 - * measures taken to restore decayed teeth and/or the dates restorations were completed

Send the above information to

United States Postal Service (USPS)
HP Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

UPS, FedEx, and DHL
HP Prior Approval Unit
ATTN: Orthodontic Review Board
2610 Wycliff Road, Suite 401
Raleigh, NC 27607

When the records are being prepared, be sure that **all** items are clearly labeled with the provider's name and the recipient's name for proper handling and return. All radiographs, models, and other parts of the orthodontic records must be of acceptable diagnostic quality or the case will be returned.

Do not occlude models. Each arch of the model must be wrapped separately in foam, bubble-plastic or a similar padding, and packed in a sturdy corrugated reusable shipping box. Boxes should be sealed with heavy, reinforced paper tape or strapping tape.

Refer to **Subsection 5.1, Prior Approval for Orthodontics Services**, for additional information.

A3: Instructions for Filing an Orthodontic Claim

Some claims must be submitted on paper. Only claims that comply with the exceptions listed on DMA's website at <http://www.ncdhhs.gov/dma/provider/ECSEExceptions.htm> may be submitted on paper. All other claims are required to be submitted electronically.

Prior to submitting electronic claims, providers must have an electronic claims submission (ECS) agreement on file. Refer to the NC Tracks website at <http://www.nctracks.nc.gov/provider/forms/> to obtain a copy of this agreement for either a group or an individual.

For those claims that are required to be billed on paper, Medicaid accepts dental claims on the 2006 ADA claim form. The following instructions are specific to that form. Paper dental claims **must** be completed in black ink only (do not highlight any portion of the claim) to allow the fiscal agent to image all dental claim forms electronically.

The following fields **must be completed as described** to allow proper processing of dental claims on the 2006 ADA claim form.

Field No.	Field Name	Explanation
12	Name	Enter the recipient's full name (Last, First, Middle) as it appears on the Medicaid card.
13	Date of Birth	Enter the recipient's date of birth using eight (8) digits (example: July 1, 2010 = 07012010).
14	Gender	Check the appropriate box: M=male, F=female.
15	Subscriber Identifier	Enter the recipient's 10-digit identification number listed on the Medicaid card.
23	Patient ID/Account #	Enter the recipient's medical record number if used by your office. This is optional but will appear on your Remittance and Status Report (RA), if entered.
24	Procedure Date	Enter the date the procedure was completed using eight (8) digits (example: July 1, 2010 = 07012010).
29	Procedure Code	Enter the five (5) digit dental procedure code rendered. Note: All procedure codes must begin with the letter "D".
30	Description	Enter the description of the procedure.
31	Fee	Enter your usual fee for the procedure, <u>not</u> the established Medicaid fee.
32	Other Fee(s)	If applicable, enter the amount of payment received from third party insurance plan(s). Do not include any payments from Medicare Part B or allowable Medicaid copayments.
33	Total Fee	Enter the total charges for all procedures listed on the claim form. Do not deduct Medicaid copayments or third-party insurance payments listed in field 32. The fiscal agent will calculate the maximum amount payable by taking into account any copayments or third-party payments.
34	Missing Teeth Information	Cross out (X) missing teeth, slash (/) teeth to be extracted, circle impacted teeth, and show space closure with arrows (←, →).
38	Place of Treatment	Check the box indicating provider's office or enter "3" as the place of treatment. Orthodontic services are covered only if delivered in a provider's office.

Instructions continued on next page

A3: Instructions for Filing an Orthodontic Claim, continued

Field No.	Field Name	Explanation
48	Name, Address, City, State, Zip Code	Enter the name, address, city, state and zip code + 4 code of the dentist or practice that is to receive payment.
49	NPI	Enter the billing provider's NPI number of the dentist or practice that is to receive payment. <ul style="list-style-type: none"> • If payment is to be made to a group practice, then enter the group NPI number. • If payment is to be made to an individual dentist, then enter the individual dentist NPI number.
52	Phone Number	Enter the area code and phone number of the billing dentist or practice.
52A	Additional Provider ID	Enter the Medicaid billing provider number (required for prior approval purposes only).
53	Signed (Treating Dentist)	Signature of the provider rendering service. The signature certifies that: "Services for which payment is requested are medically necessary and indicated in the best interest of the recipient's oral health. The provider's signature on Medicaid documents and claims shall be binding and shall certify that all information is accurate and complete." In order to submit claims without a signature on each claim, a "Provider Certification for Signature on File" form must be submitted to Provider Enrollment at HP. The form is located at http://www.nctracks.nc.gov/provider/forms/pc.pdf
54	NPI	Enter the attending provider's NPI number for the individual dentist rendering service. This number should correspond to the signature in field 53.
56	Name, Address, City, State, Zip Code	Enter the name, address, city, state, and zip code + 4 code.
56A	Provider Specialty Code	Enter the attending provider's taxonomy.

Send claims to

HP
PO Box 30968
Raleigh, NC 27622

Claim forms may be ordered directly from the ADA.

<http://www.ada.org/ada/prod/catalog/index.asp>

Telephone: 1-800-947-4746

American Dental Association
Attn: Salable Materials Office
211 E Chicago Avenue
Chicago, IL 60611-2678

A4: Example of a Completed Claim for Orthodontic Records

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
 Statement of Actual Services Request for Predetermination/Preeuthorization
 EPSOT/Title XIX

2. Predetermination/Preeuthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscrber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Baker, Frances T.

13. Date of Birth (MM/DD/CCYY) 14. Gender 15. Policyholder/Subscrber ID (SSN or ID#)
05/07/1994 M F **598694859H**

16. Plan/Group Number 17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip 5-11) Yes (Complete 5-11)

5. Name of Policyholder/Subscrber in #4 (Last, First, Middle Initial, Suffix)

PATIENT INFORMATION

6. Date of Birth (MM/DD/CCYY) 7. Gender 8. Policyholder/Subscrber ID (SSN or ID#)
 M F

9. Plan/Group Number 10. Patient's Relationship to Person Named in #5
 Self Spouse Dependant Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

18. Relationship to Policyholder/Subscrber in #12 Also
 Self Spouse Dependant Other 19. Student Status
 Y N PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender 23. Patient ID/Account # (Assigned by Dentist)
 M F

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	03/14/2010					D015	Comprehensive oral evaluation	50.00
2	03/14/2010					D007	Periapical film	100.00
3	03/14/2010					D0040	Cephalometric radiograph	60.00
4	03/14/2010					D0040	Diagnostic casts	50.00
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

											Primary												32. Other Fee(s)										
1	2	3	4	5	6	7	8	9	10	11	A	B	C	D	E	F	G	H	I	J	T	S	R	Q	P	O	N	M	L	K	33 Total Fee		
																																260.00	

35. Remarks

AUTHORIZATION

36. I have been informed of the treatment plan and associated costs, and I understand that I am responsible for all charges for dental services and materials not covered by benefits provided by law, or the treating dental practice has agreed with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I hereby consent to the performance and disclosure of my protected health information to carry out the treatment plan in connection with this claim.

X Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment
 Provider's Office Hospital ECF Other

39. Number of Enclosures (00 to 99)
 Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics?
 No (Skip 41-42) Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining 43. Replacement of Prosthesis?
 No Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
 Occupational Illness/Injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscrber)

48. Name, Address, City, State, Zip Code
**Dr. John Hancock
567 Any Street
City, NC 27777-7777**

49. NPI 50. License Number 51. SSN or TIN
9999999999

52. Phone Number 53. Additional Provider ID
(919) 333 - 0000

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X **John Hancock, DDS** **03/15/2010**
 Signed (Treating Dentist) Date

54. NPI 55. License Number
9999999999

56. Address, City, State, Zip Code 56A. Provider Specialty Code
567 Any Street, City, NC 27777-7777 **XXXXXXXXXX**

57. Phone Number 58. Additional Provider ID
(919) 333-0000

© 2006 American Dental Association
 J400 (Same as ADA Dental Claim Form - J401, J402, J403, J404)

To Reorder call 1-800-947-4746
 or go online at www.adacatalog.org

A5: Orthodontic Treatment Termination Form

Providers must submit an Orthodontic Treatment Termination Form when a case is terminated. Supporting documentation, such as when and how attempted contacts were made (such as information indicating telephone calls made, messages left with neighbors or friends, letters, etc.) must be attached to this form. (See an example of this form on the next page.)

Send the Orthodontic Treatment Termination Form to

HP Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

Refer to **Subsection 7.3, Terminated Orthodontic Treatment**, for additional information. This form is available on DMA's website at <http://www.ncdhhs.gov/dma/forms/orthotreattermreq.pdf>.

**NORTH CAROLINA MEDICAID PROGRAM
ORTHODONTIC TREATMENT TERMINATION REQUEST**

Date: _____

Return this letter to:

HP Prior Approval Unit
Attn: Orthodontic Review Board
P.O. Box 31188
Raleigh, NC 27622

Recipient name: _____

Medicaid ID #: _____

Months in treatment = _____

Estimated months needed to complete treatment = _____

Date of termination = _____

Reason for termination (check box and attach any supporting documentation):

- recipient moved out of state
- recipient transferred to another provider (specify) _____
- recipient death
- recipient non-compliance
- other (specify) _____

Retainers delivered (please circle): Upper yes or no Lower yes or no

Date retainers delivered: _____

Number of paid maintenance visits: _____

If the recipient was only banded, Medicaid may require that a percentage of the banding fee be refunded to the program. Medicaid will contact the provider to make arrangements for the refund.

Provider number: _____

Provider name: _____

Provider address: _____

Provider phone: _____

A6: Orthodontic Treatment Extension Request

It is anticipated that the orthodontic treatment will be completed within 36 months. Providers must submit an Orthodontic Treatment Extension Request whenever treatment extends beyond the original 36-month approval period. Claims submitted after the approval authorization expires will deny with EOB 2123 “This case has exceeded the initial 36 months approved. Resubmit with a written extension request. Document reason and anticipated completion date to HP/Prior Approval Unit”. Until an extension request has been submitted in such cases, Medicaid claims will deny. Two copies of this request are required so that HP can notify the provider once the extension period has been granted. (See an example of this form on the next page.)

Send the Orthodontic Treatment Extension Request to

HP Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

Refer to **Subsection 7.4, Orthodontic Treatment Extension Request**, for additional information. This form is available on DMA’s website at <http://www.ncdhhs.gov/dma/forms/orthotreatextreq.pdf>.

**NORTH CAROLINA MEDICAID PROGRAM
ORTHODONTIC TREATMENT EXTENSION REQUEST**

Note: Providers are reminded that reimbursement for extended orthodontic treatment is limited to the remaining number of periodic maintenance visits for that recipient (total of twenty-three visits).

Date: _____

Return this letter to:
HP Prior Approval Unit
Attn: Orthodontic Review Board
P.O. Box 31188
Raleigh, NC 27622

Recipient name: _____

Medicaid ID #: _____

Months in treatment = _____

Estimated months needed to complete treatment = _____

Number of paid maintenance visits: _____

Reason for extension: _____

Provider number: _____

Provider name: _____

Provider address: _____

Provider phone: _____

HP Orthodontic Prior Approval Use Only

Extension Request: Approved () Denied ()

Revised Prior Approval End Date: _____

A7: Orthodontic Post Treatment Summary

Upon case completion, an Orthodontic Post Treatment Summary must be submitted to the address listed below. (See an example of this form on the next page.) If fewer than 12 maintenance visits were paid, attach copies of the recipient's chart notes.

Send the Orthodontic Post Treatment Summary to

HP Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

Refer to **Subsection 7.5, Orthodontic Case Completion**, for additional information. This form is available on DMA's website at <http://www.ncdhhs.gov/dma/forms/orthposttreat.pdf>.

**NORTH CAROLINA MEDICAID PROGRAM
ORTHODONTIC POST TREATMENT SUMMARY**

Date: _____

Return this letter to:

HP Prior Approval Unit
Attn: Orthodontic Review Board
P.O. Box 31188
Raleigh, NC 27622

Recipient name: _____

Medicaid ID #: _____

Active phase of treatment has been completed. Date of debanding: _____

Retainers delivered (please circle): Upper yes or no Lower yes or no

Date retainers delivered: _____

Results obtained (please circle): excellent good fair poor

Assessment of recipient cooperation: excellent good fair poor

Comments: _____

Number of paid maintenance visits: _____

If fewer than 12 maintenance visits were paid, records review is required to substantiate the final claim payment. If it is determined that treatment was not "completed" but rather "terminated", the final payment will not be allowed.

Provider number: _____

Provider name: _____

Provider address: _____

Provider phone: _____