



Department of Health and Social Services

# Orthodontia Services

Health Care Services

Statement of Coverage  
11/9/2009

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## Orthodontic Services

Effective November 9, 2009, Alaska Medicaid and Denali KidCare will cover orthodontia services for certain recipients meeting established criteria. This guide will explain recipient eligibility, criteria and prior authorization requirements for orthodontia services covered by Alaska Medicaid.

## Providers

Providers are encouraged to review regulations concerning orthodontia services:

7 AAC 145.005 (h)(2) states that a provider may not charge a higher rate for any unit of service provided to a Medicaid recipient than the provider charges others, except for an amount billed Medicare.

7 AAC 110.150 (8)(A) requires that orthodontia services be performed by an orthodontist.

## Recipient Eligibility

- a. Orthodontia services are restricted to recipients aged 20 years and younger. It is expected that treatment will be completed before the recipient turns 21 years of age.
- b. If a recipient's eligibility ends before the conclusion of treatment, then payment for remaining services is the responsibility of the parent or guardian. It is recommended that the parent or guardian sign a statement that if the recipient's Medicaid eligibility ends during orthodontic treatment, the parent or guardian may be held responsible for payment of the remaining orthodontic treatment. Alaska Medicaid will not cover remaining treatment for a recipient no longer eligible for Medicaid or Denali KidCare.
- c. When the orthodontist determines that treatment needs to be discontinued either from non-compliance, or the recipient is no longer eligible for Medicaid or Denali KidCare, the orthodontist will need to remove and replace the brackets with retention if needed.
- d. When a patient is uncooperative for any reason, termination of treatment will be left to the discretion of the provider. A statement reporting the termination of treatment must be sent to Affiliated Computer Services within 30 days of termination of treatment.

## Limited Orthodontic Treatment

### *Definition and criteria for services*

According to the American Dental Association's Current Dental Terminology publication, limited orthodontic treatment is orthodontic treatment with a limited objective, not involving the entire dentition. Treatment may be directed at the existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

### *Prior Authorization Requirements*

Limited orthodontic services require prior authorization. On the prior authorization form provided by the Department, include:

1. A description of the problem;
2. A description of the appliance(s);
3. A scored Handicapping Labiolingual Deviation (HLD) Index Report completed and signed by the orthodontist;
4. Panoramic films, intra and extra oral photos;
5. Written comprehensive orthodontic treatment plan; and
6. Other pertinent medical/dental information to support the requested orthodontic treatment (e.g. extractions, gingivectomy or orthognathic surgery).

Prior approval for limited orthodontics is not considered approval for interceptive or comprehensive orthodontics in a multi-phase plan.

A one-time reimbursement is provided for limited orthodontic treatment to include the appliance(s) and all medically necessary treatment.

CDT Code	Description	Maximum Allowable Fee
D8010	Limited orthodontic treatment of the primary dentition	\$1500.00
D8020	Limited orthodontic treatment of the transitional dentition	\$1677.00
D8030	Limited orthodontic treatment of the adolescent dentition	\$2000.00

If a second phase is anticipated after limited orthodontic treatment has begun, submission of a completed Handicapping Labiolingual Deviation (HLD) Index Report is mandatory. In the event that less than eighteen (18) months have elapsed between the last treatment of limited orthodontics and the commencement of an approved comprehensive plan, the reimbursement received for the limited plan will be deducted from the reimbursement for the comprehensive plan.

## Interceptive Orthodontic Treatment

### *Definition and criteria for services*

According to the American Dental Association's Current Dental Terminology publication, interceptive orthodontic treatment is indicated for procedures to lessen the severity or future effects of a malformation and to eliminate its cause and may include localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite or recovery of recent minor space loss where overall space is adequate.

Alaska Medicaid and Denali KidCare consider successful interception to be intervention in the incipient stages of a developing problem to lessen the severity of the malformation and eliminate its cause or complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions that may require future comprehensive therapy.

Interceptive orthodontic treatment is limited to individuals up to 13 years of age. A one-time reimbursement is provided for interceptive orthodontic treatment to include the appliance(s) and all medically necessary treatment.

### *Prior Authorization Requirements*

Interceptive orthodontics requires prior authorization. On the prior authorization form provided by the Department, include:

1. A description of the problem;
2. A description of the appliance(s);
3. A scored Handicapping Labiolingual Deviation (HLD) Index Report completed and signed by the orthodontist;
4. Panoramic films, intra and extra oral photos;
5. Written comprehensive orthodontic treatment plan; and
6. Other pertinent medical or dental information to support the requested orthodontic treatment (e.g. extractions, gingivectomy or orthognathic surgery)

Prior approval for interceptive orthodontics is not considered approval for comprehensive orthodontics in a multi-phase plan.

*Reimbursement for Interceptive Orthodontic Treatment*

Reimbursement is available for fixed or removable appliance therapy and is based on the type of appliance and treatment plan up to the maximum allowable.

A one-time reimbursement for interceptive orthodontics includes the appliance(s), the placement of the appliance(s), all active treatment visits and all follow-up visits.

DT Code	Description	Maximum Allowable Fee
D8050	Interceptive orthodontic treatment of the primary dentition	\$2000.00
D8060	Interceptive orthodontic treatment of the transitional dentition	\$2145.00

If a second phase is anticipated after interceptive orthodontic treatment has begun, submission of a completed Handicapping Labiolingual Deviation (HLD) Index Report is mandatory. In the event that less than eighteen (18) months have elapsed between the last treatment of interceptive orthodontics and the commencement of an approved comprehensive plan, the reimbursement received for the interceptive plan will be deducted from the reimbursement for the comprehensive plan.

## Comprehensive Orthodontic Treatment

### *Definition and criteria for services*

According to the American Dental Association's Current Dental Terminology publication, comprehensive orthodontic treatment is used to improve a patient's craniofacial dysfunction and or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care may be coordinated disciplines. Optimal care requires long-term consideration of patient's needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development.

### *Prior Authorization Requirements*

Comprehensive orthodontic treatment requires prior authorization. On the prior authorization form provided by the Department include:

1. A description of the problem;
2. A description of the appliance(s);
3. A scored Handicapping Labiolingual Deviation (HLD) Index Report completed and signed by the orthodontist;
4. Panoramic films, intra and extra oral photos;
5. Written comprehensive orthodontic treatment plan; and
6. Other pertinent medical or dental information to support the requested orthodontic treatment (e.g. extractions, gingivectomy, or orthognathic surgery).

When requesting approval for orthodontic treatment the provider should consider the patient's willingness and ability to attend scheduled appointments and the patient's ability to maintain an acceptable level of oral hygiene, which is vital to the success of orthodontic treatment.

### *Policies for approval of Comprehensive Orthodontic Treatment*

1. The score for the HLD must be 26 or greater
2. If the score is less than 26, then additional medical information is required to determine the recipient's functional abilities
3. Prior authorizations will not be approved for treatment that has been rendered retroactive to the date of the prior authorization submission
4. Orthodontic services are only available to recipients aged 20 years and younger. It is expected that treatment will be completed before the recipient turns 21 years of age.

Approved comprehensive orthodontic treatment will be prior authorized and the provider is responsible to request each prior authorization.

CDT Code	Description	Requirements	Maximum Allowable Fee
D8080 or D8070	Comprehensive orthodontic treatment of the adolescent dentition Comprehensive orthodontic treatment of the transitional dentition	Reimbursement is provided for the initial placement when the appliance placement date and the date of service are the same. Initial placement includes the first three months of treatment and the appliance(s).	\$1,500.00
D8670	Periodic orthodontic treatment visit (as part of contract)	Reimbursement is provided for three units of service. The provider must examine the patient in the provider's office and document the actual service dates in the client's record to support claiming a unit of service. The Department expects providers to submit a claim for reimbursement following 6 and 12 months of treatment with a final claim submitted after removal of the braces.	\$1,348.00 x three units
Total Maximum Allowable:			\$5,544.00