

Table of Contents

1.0 Description of the Procedure, Product, or Service..... 1
1.1 Definitions 1

2.0 Eligibility Requirements 1
2.1 Provisions..... 1
2.1.1 General..... 1
2.1.2 Specific 1
2.2 Special Provisions..... 2
2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid
Beneficiary under 21 Years of Age 2
2.2.2 EPSDT does not apply to NCHC beneficiaries 3
2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through
18 years of age 3
2.3 Limitations 3

3.0 When the Procedure, Product, or Service Is Covered..... 4
3.1 General Criteria Covered 4
3.2 Specific Criteria Covered..... 4
3.2.1 Specific criteria covered by both Medicaid and NCHC 4
3.2.2 Medicaid Additional Criteria Covered..... 4
3.2.3 NCHC Additional Criteria Covered 5

4.0 When the Procedure, Product, or Service Is Not Covered..... 5
4.1 General Criteria Not Covered 5
4.2 Specific Criteria Not Covered..... 5
4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC..... 5
4.2.2 Medicaid Additional Criteria Not Covered..... 5
4.2.3 NCHC Additional Criteria Not Covered..... 6

5.0 Requirements for and Limitations on Coverage 6
5.1 Prior Approval 6
5.2 Prior Approval Requirements 7
5.2.1 General..... 7
5.3 Limitations or Requirements..... 7
5.3.1 Comprehensive Orthodontic Treatment..... 7
5.4 ADA-Approved Materials 9
5.5 Orthodontic Review Board 9
5.6 Orthodontic Records 10
5.7 Notifications to the Provider..... 10
5.8 Periodic Maintenance Visits 10
5.9 Reimbursement of Orthodontic Maintenance Visits During Ineligible Periods 11
5.10 Request for Special Approval of a Non-Covered Service or Service Outside the Policy
Limitations..... 11

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service 12
6.1 Provider Qualifications and Occupational Licensing Entity Regulations..... 12
6.2 Provider Certifications 12

7.0	Additional Requirements	12
7.1	Compliance	12
7.2	Orthodontic Transfer Cases	12
	7.2.1 In-State Transfer Cases	12
	7.2.2 Out-of-State Transfer Cases.....	13
7.3	Terminated Orthodontic Treatment	13
7.4	Orthodontic Treatment Extension Request (when paid maintenance visits have not exceeded the 23 allowed).....	14
7.5	Orthodontic Case Completion.....	14
7.6	Health Record Documentation.....	15
7.7	Transfer of Beneficiary Dental Records	15
8.0	Policy Implementation/Revision Information.....	16
Attachment A: Orthodontic Billing Guide.....		18
A1:	Instructions for Requesting Orthodontic Prior Approval.....	18
A2:	Example of a Completed Orthodontic Prior Approval Request.....	19
A3:	Instructions for Filing an Orthodontic Claim.....	20
	Instructions for Filing an Orthodontic Claim, continued	21
A4:	Example of a Completed Claim for Orthodontic Records	23
A5:	Orthodontic Treatment Termination Request	24
A6:	Orthodontic Treatment Extension Request.....	26
A7:	Orthodontic Post Treatment Summary	28

1.0 Description of the Procedure, Product, or Service

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 (NC) Medicaid and Health Choice Dental Programs.**

The Division of Medical Assistance (DMA) has adopted procedure codes and descriptions as defined in the most recent edition of *Current Dental Terminology* (CDT 2015).

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term "Specific" found throughout this policy only applies to this policy)

a. Medicaid

None Apply.

b. NCHC

None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 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 beneficiary 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 practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or 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 beneficiary'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 beneficiary's right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. 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 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 meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

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

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

2.3 Limitations

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

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when 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 beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and 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 beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

The following criteria for functionally impairing occlusal conditions apply when cases are reviewed for 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 (beneficiary'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 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.

3.2.3 NCHC Additional Criteria Covered

NCHC shall allow coverage of orthodontic services **only** for severe malocclusions caused by craniofacial anomalies like cleft lip and palate or other conditions caused by a syndrome.

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

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Orthodontic services are not covered when the criteria specified in **Section 3.0** and **Section 5.0** of this policy have not been met.

4.2.2 Medicaid Additional Criteria Not Covered

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 and 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 (including splint therapy for the treatment of temporomandibular dysfunction).
- l. Orthodontic treatment started as a private pay arrangement before Medicaid approval is requested or granted.

If a non-covered orthodontic service is deemed medically necessary and warrants consideration of approval, the provider shall submit a prior approval request along with a letter describing the special circumstances of the case and appropriate orthodontic records. (Refer to **Subsection 5.10, Request for Special Approval of a Non-Covered Service or Service Outside the Policy Limitations**, for specific instructions on submitting a prior approval request.)

4.2.3 NCHC Additional Criteria Not Covered

- a. NCHC shall not cover orthodontic services when the NCHC beneficiary does not have a severe malocclusion caused by a craniofacial anomaly like cleft lip and palate or other conditions caused by a syndrome
- b. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

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 beneficiary. 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 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.3 Limitations or Requirements

By State legislative authority, DMA applies service limitations to ADA procedure codes as they relate to individual beneficiaries. 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 beneficiary under age 21. Refer to **Subsection 5.10, 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 or NCHC 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 retainers, etc.

Code	Description	PA Needed?
D8070	Comprehensive orthodontic treatment of the transitional dentition * limited to Medicaid beneficiaries under age 21 * limited to NCHC beneficiaries under age 19 * limited to functionally impairing malocclusions caused by cleft lip and 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 beneficiary under age 21 * once in a lifetime service for a NCHC beneficiary	Yes

Code	Description	PA Needed?
D8080	<p>Comprehensive orthodontic treatment of the adolescent dentition</p> <ul style="list-style-type: none"> * limited to Medicaid beneficiaries under age 21 * limited to NCHC beneficiaries under age 19 * 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 for Medicaid beneficiaries * limited to severe malocclusions caused by craniofacial anomalies like cleft lip and palate and other conditions caused by a syndrome for NCHC beneficiaries * once in a lifetime service unless special approval is granted for services deemed medically necessary for a Medicaid beneficiary under age 21 * once in a lifetime service for a NCHC beneficiary 	Yes
D8670	<p>Periodic orthodontic treatment visit</p> <ul style="list-style-type: none"> * limited to Medicaid beneficiaries under age 21 * limited to NCHC beneficiaries under age 19 * use for monthly maintenance visit * allowed once per calendar month * limited to functionally impairing malocclusions for Medicaid beneficiaries * limited to severe malocclusions caused by craniofacial anomalies like cleft lip and palate or other conditions caused by a syndrome for NCHC beneficiaries * 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 or NCHC 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 beneficiary's 21st birthday for Medicaid beneficiaries * once a case is approved, it is anticipated that all banding and monthly maintenance visits will be completed by the beneficiary's 19th birthday for NCHC beneficiaries 	Yes

Code	Description	PA Needed?
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) * limited to Medicaid beneficiaries under age 21 * limited to NCHC beneficiaries under age 19 * once in a lifetime service unless special approval is granted for services deemed medically necessary for a Medicaid beneficiary under age 21 * once in a lifetime service for a NCHC beneficiary * 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 or NCHC payment and the beneficiary must **not** be billed any additional charges.

5.4 ADA-Approved Materials

Only dental materials accepted by the ADA Council on Dental Therapeutics shall be accepted for use in the dental care of Medicaid and NCHC beneficiaries. Specific use of these materials must follow the ADA Council on Dental Therapeutics guidelines.

5.5 Orthodontic Review Board

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

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

5.6 Orthodontic Records

It is essential that Medicaid or NCHC eligibility be confirmed on the date of the orthodontic records. If the beneficiary is not eligible, no payment is made.

Note: Orthodontic records must only be taken for NCHC beneficiaries if the beneficiary has a severe malocclusion caused by a craniofacial anomaly like cleft lip and palate or a condition caused by a syndrome. Records are not reimbursed for NCHC beneficiaries who do not meet these criteria.

Medicaid and NCHC shall not cover interceptive orthodontics. Therefore, professional judgment must 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 – new or established patient
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.

5.7 Notifications to the Provider

Once a decision is made regarding the request for orthodontic services, written notification is sent to the provider.

- a. If the case is approved, CSC will send an electronic Notice of Decision to the provider through NC Tracks and return all orthodontic records.
- b. If the case is denied, CSC will send an electronic Notice of Decision to the provider through NC Tracks and return all orthodontic records. A letter of notification of denial, along with appeal rights, is mailed to the beneficiary. A copy of the denial letter is also mailed to the provider.

5.8 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.

5.9 Reimbursement of Orthodontic Maintenance Visits During Ineligible Periods

It is essential that Medicaid or NCHC eligibility be confirmed on the date of banding. If the beneficiary is not eligible, no payment will be made. Orthodontic periodic maintenance visits are reimbursed regardless of the beneficiary's eligibility status at that visit as long as the beneficiary 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 are covered during ineligible periods. Providers shall make the beneficiary aware that Medicaid or NCHC will not pay for any routine care, restorative care, extractions, or orthognathic surgery needed during orthodontic treatment if rendered during ineligible periods.

5.10 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 beneficiary 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 beneficiary's medical care provider), and
- c. the completed Non-Covered State Medicaid Plan Services Request Form for Beneficiaries 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 beneficiary'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.

Enter a prior approval request in the NC Tracks Prior Approval Portal or mail requests to

**CSC Prior Approval Unit
PO Box 31188
Raleigh, N.C. 27622**

If the procedure(s) receives special approval and the beneficiary 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 Beneficiaries Under 21 Years of Age can be found on the EPSDT provider page at <http://www.ncdhhs.gov/dma/epsdt/>.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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 and NCHC programs must provide services in accordance with the rules and regulations detailed in this policy.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Orthodontic Transfer Cases

The beneficiary shall be receiving orthodontic treatment that was approved by Medicaid or NCHC 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 beneficiary'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 or NCHC orthodontic approval marked “VOID”.

Enter a prior approval request in the NC Tracks Prior Approval Portal or mail the request to the CSC 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 beneficiary.

7.2.2 Out-of-State Transfer Cases

The beneficiary 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 beneficiary’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 required.

Enter a prior approval request in the NC Tracks Prior Approval Portal or mail the request to the CSC 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 beneficiary.

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 beneficiary 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 beneficiary death or moving out of state) that prevent orthodontic treatment completion, the provider shall notify CSC. 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, enter a prior approval request for procedure code D8680 (orthodontic retention) with a copy of the beneficiary records in the NC Tracks Prior Approval Portal or mail the request to the CSC Prior Approval Unit, Orthodontic Review Board. Copies of the beneficiary records are required to substantiate payment. If less than 6 maintenance visits were rendered, no additional reimbursement is allowed since payment received for the banding constitutes about one-third of the maximum allowed for the entire treatment.

If the beneficiary was only banded, Medicaid or NCHC may require that a percentage of the banding fee be refunded to the program. This is based on individual case consideration and the circumstances surrounding case termination. In these cases, Medicaid or NCHC shall 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 Request.

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 shall submit a written treatment extension request. Fax this form to CSC at (855) 710-1964.

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 request for payment of the balance of remaining visits. The request will be considered based on the number of remaining visits and the outcome of the case.

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 is not allowed.

At case completion, enter a prior approval request for procedure code D8680 (orthodontic retention) along with an Orthodontic Post Treatment Summary in the NC Tracks Prior Approval Portal or mail the request to the CSC Prior Approval Unit, Orthodontic Review Board. The request will be manually priced and Medicaid or NCHC will allow reimbursement based on the number of remaining visits if the case is determined to be a completed case. The post-treatment summary includes the results of the treatment and assessment of the beneficiary’s cooperation. It is important that Medicaid and NCHC receive a post-treatment summary in order to complete case records. The final

orthodontic claim will not be paid unless a post-treatment summary is submitted and procedure code D8680 is approved.

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

7.6 Health 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/NCHC. 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 beneficiary 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 or NCHC.

The N.C. State Board of Dental Examiners applicable rule regarding patient records [21 NCAC 16T. 0101(a)] 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 or NCHC (45 CFR 164.502).

7.7 Transfer of Beneficiary Dental Records

Providers are reminded to provide records of diagnostic quality when transferring dental records to another provider or directly to a beneficiary. 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 or images that are transferred are of diagnostic quality so the provider receiving the radiographs can make a proper diagnosis regarding treatment.

The provider shall comply with 21 NCAC 16T.0102, Transfer of Records Upon Request, which states: *“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.”*

Medicaid and NCHC policy does not prohibit a dentist from charging a record duplication fee to a beneficiary, 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 CSC 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; 5.2; and 5.7	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 2.0; 3.0; 4.0; and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under age 21 years of age.
06/01/2007	Section 5.6	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; 5.2; and Attachment A (Orthodontic Billing Guide).	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 beneficiaries covered under the Medicare Qualified Beneficiaries program; added statements regarding beneficiaries 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.
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;	Updated policy to standard DMA language; changed "functionally handicapping" to

Date	Section Revised	Change
	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.	“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.
10/1/2011	Throughout	Session Law 2011-145 “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the NC Health Choice Program shall be equivalent to coverage provided for dependents under the North Carolina Medicaid Program.”. DMA was given the timeframe October 1, 2011 to March 12, 2012 to fully implement the NCHC transition to a Medicaid look-alike program.
3/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Changed fiscal agent references from HP to CSC throughout the document; Updated CDT-2015 procedure code descriptions effective with date of service 1/1/2015; Updated place of service references to HIPAA standards; and updated instructions related to CSC processing.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Orthodontic Billing Guide

A1: Instructions for Requesting 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 must be taken:

- a. Enter a prior approval request in the NC Tracks Prior Approval Portal or mail the request to the CSC Prior Approval Unit, Orthodontic Review Board.
- b. The request should include the orthodontic records – panoramic film (D0330), cephalometric film (D0340), and diagnostic casts (D0470) and the date that the records were rendered.
- c. The request should also include the procedure code for the orthodontic treatment being requested (D8070 or D8080).

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 or NCHC)
- e. A written narrative which includes:
 - * the provider's assessment of the beneficiary's motivation, ability to cooperate for orthodontic care, and ability to maintain oral hygiene
 - * the provider's assessment of the beneficiary's oral condition and the need for treatment
 - * the provider's assessment of the beneficiary'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)
CSC Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

UPS, FedEx, and DHL
CSC Prior Approval Unit
ATTN: Orthodontic Review Board
2610 Wycliff Road, Suite 102
Raleigh, NC 27607

When the records are being prepared, be sure that **all** items are clearly labeled with the provider's name and the beneficiary'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 must be sealed with heavy, reinforced paper tape or strapping tape.

Refer to **Subsection 5.1, Prior Approval**, 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/ECSExceptions.htm> may be submitted on paper. All other claims are required to be submitted electronically.

Prior to submitting electronic claims, providers shall 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 and NCHC 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
1	Type of Transaction	Check the appropriate box: <ul style="list-style-type: none"> • State of Actual Services (claim) • Request for Predetermination (prior approval request) • EPSDT/Title XIX
12	Name	Enter the beneficiary's full name (Last, First, Middle) as it appears on the Medicaid or NCHC card.
13	Date of Birth	Enter the beneficiary'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 beneficiary's 10-digit identification number listed on the Medicaid or NCHC card.
23	Patient ID/Account #	Enter the beneficiary'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, 2015 = 07012015).
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 and NCHC 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 or NCHC copayments.

Instructions continued on next page

Instructions for Filing an Orthodontic Claim, continued

Field No.	Field Name	Explanation
33	Total Fee	Enter the total charges for all procedures listed on the claim form. Do not deduct Medicaid or NCHC 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 (← →).
35	Remarks	Enter the billing provider's taxonomy.
38	Place of Treatment	Enter "11" as the place of treatment. Orthodontic services are covered only if delivered in a provider's office.
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.
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 beneficiary's oral health. The provider's signature on Medicaid and NCHC documents and claims shall be binding and shall certify that all information is accurate and complete."
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.

Submit claims electronically or mail claims to the address listed below.

For Medicaid and NCHC claims:

CSC

PO Box 30968

Raleigh, N.C. 27622

Claim forms may be ordered directly from the ADA.

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

Telephone: 1-800-947-4746

Address:

American Dental Association

Attn.: Salable Materials Office

211 E. Chicago Avenue

Chicago, IL. 60611-2678

A5: Orthodontic Treatment Termination Request

Providers shall submit an Orthodontic Treatment Termination Request 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. (Refer to an example of this form on the next page.)

Send the Orthodontic Treatment Termination Form to

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

Fax to CSC: (855) 710-1964

Refer to **Subsection 7.3, Terminated Orthodontic Treatment**, for additional information. This form is available in NC Tracks at <https://www.nctracks.nc.gov/content/public/providers/prior-approval.html>.



NORTH CAROLINA MEDICAID PROGRAM



ORTHODONTIC TREATMENT TERMINATION REQUEST

Date: _____

Return this letter to:

PA
PO Box 31188
Raleigh, NC 27622-1188

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: _____

Fax this form to CSC at: (855) 710-1964

DMA-0007

A6: Orthodontic Treatment Extension Request

It is anticipated that the orthodontic treatment will be completed within 36 months. Providers shall 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 CSC Prior Approval Unit”. Until an extension request has been submitted in such cases, Medicaid or NCHC claims will deny. (Refer to an example of this form on the next page.)

Send the Orthodontic Treatment Extension Request to

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

Fax to CSC: (855) 710-1964

Refer to **Subsection 7.4, Orthodontic Treatment Extension Request**, for additional information. This form is available in NC Tracks at <https://www.nctracks.nc.gov/content/public/providers/prior-approval>.



**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:

PA
PO Box 31188
Raleigh, NC 27622-1188

Recipient name: _____

Medicaid ID #: _____

Months in treatment = _____

Estimated months needed to complete treatment = _____

Reason for extension: _____

Number of paid maintenance visits: _____

Provider number: _____

Provider name: _____

Provider address: _____

Provider phone: _____

Fax this form to CSC at: (855) 710-1964

DMA-0006

A7: Orthodontic Post Treatment Summary

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

Send the Orthodontic Post Treatment Summary to

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

Fax to CSC: (855) 710-1964

Refer to **Subsection 7.5, Orthodontic Case Completion**, for additional information. This form is available in NC Tracks at <https://www.nctracks.nc.gov/content/public/providers/prior-approval.html>.



NORTH CAROLINA MEDICAID PROGRAM
ORTHODONTIC POST TREATMENT SUMMARY

Date: _____

Return this letter to:

PA
PO Box 31188
Raleigh, NC 27622-1188

Recipient name: _____

Recipient 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: _____

Fax this form to CSC at: (855) 710-1964

DMA-0005