

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.



Director, Program Policy Division  
Bureau of Policy and Federal Affairs  
Policy and Legal Affairs Administration

<b>Project Number:</b>	0155-Dental	<b>Comments Due:</b>	4/11/02	<b>Proposed Effective Date:</b>	July 1, 2002
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**Policy Subject:** Orthodontic policy for CSHCS beneficiaries

**Affected Programs:** CSHCS

**Distribution:** Dentists and Dental Clinics

**Policy Summary:** Policy changes to the prior authorization and billing system for orthodontics for CSHCS beneficiaries.

# Proposed Policy Draft

Michigan Department of Community Health  
Medical Services Administration

**Distribution:** Dentists and Dental Clinics

**Issued:** May 1, 2002

**Subject:** Orthodontic Policy and Billing Instructions

**Effective:** July 1, 2002

**Programs Affected:** Children's Special Health Care Services (CSHCS)

As part of an ongoing effort to reduce the administrative burden for dental providers, the Department of Community Health (DCH) has reviewed current requirements related to the authorization and claims submission for orthodontic services for Children's Special Health Care Services (CSHCS) beneficiaries. The orthodontic procedure codes, prior authorization and billing instructions for CSHCS have been revised and are described as follows.

Effective for dates of service on and after July 1, 2002, the prior authorization instructions and billing instructions for orthodontics will change. The pre-orthodontic evaluation and x-rays, including cephalometric x-rays, will not require prior authorization. The pre-orthodontic evaluation will include the exam and study models. X-rays are to be billed separately. All other orthodontic services will require prior authorization.

The DCH has implemented use of the procedure codes found in the American Dental Association's CDT-3 procedure code manual. Please see the Dental Procedure Codes Appendix to view the covered procedure codes and descriptions. Included in the Appendix are the procedure codes that are applicable to the CSHCS program and require prior authorization for beneficiaries with qualifying diagnoses appropriate for orthodontic treatment.

Effective for dates of service on and after July 1, 2002, only one prior authorization request will be needed for each stage of orthodontic treatment. Once issued, a new prior authorization number will be effective up to a two-year period. Providers will no longer have to submit new requests every six months. A complete treatment plan is required with the submission of the prior authorization request along with a time frame in which the treatment is expected to be completed. Depending on the treatment requested, some services may be paid in full and other services will be paid in quarterly installments over a two-year period. Prior authorization requests will not be extended beyond the two-year period.

For example, when a provider requests D8050, Interceptive treatment of the primary dentition, the request must include the complete treatment plan for the beneficiary and the expected time frame to complete the treatment. Upon submission of the claim, the provider will receive a single payment as payment in full for the entire treatment period.

When the provider enters into the next stage of treatment, such as D8070, Comprehensive treatment of the transitional dentition, the request must include the complete treatment plan, including surgery, and the expected time frame to complete the treatment. An initial payment will be made and the remaining payments will be made quarterly. The prior authorization number will be used for the entire two-year period. The treatment plans will be kept on file with the Prior Authorization Unit. This eliminates the need for providers to submit a prior authorization request every six months and gives staff an accurate view of the length of time during which treatment is rendered.

When submitting the initial prior authorization request, the provider should list the appropriate orthodontic treatment procedure code on line one, and then on the subsequent lines the periodic orthodontic treatment visit procedure code (D8670) should be listed. This may be listed up to a total of seven times, depending on the expected time frame for treatment.

The prior authorization request must be submitted and treatment started 12 months prior to the 21<sup>st</sup> birthday of the beneficiary. No treatment will be authorized for beneficiaries beyond age 21.

If the beneficiary leaves and goes to another orthodontist provider before completing treatment, the initial orthodontist will receive a pro-rated payment for the treatment already provided and the balance will be paid to the provider who completes the treatment, up to the maximum amount allowed for the procedure code.

Effective July 1, 2002, those cases that have already been started will be pro-rated for payment up to the maximum amount allowed for the procedure code. If the treatment has already been paid up to the maximum allowable amount, no additional monies will be paid and the orthodontic benefit will be considered paid in full.

Effective July 1, 2002, a frequency limitation will apply to the procedure code D8692, Replacement of lost or broken retainer. The CSHCS program will only pay for two retainers in a two-year period.

Below is the list of procedure codes and proposed payment rates for orthodontic treatment.

Procedure Codes	Code Description	Information	Fee Screen
D8660	Pre-orthodontic treatment	Includes exam and study models	\$107.09
D0340	Cephalometric film	Bill x-rays separately; no PA needed for cephalometric	\$28.39
D8050	Interceptive orthodontic treatment of the primary dentition	PA required only once; payment in full upon submission of claim	\$1260.00
D8060	Interceptive orthodontic treatment of the transitional dentition	PA required only once; payment in full upon submission of claim	\$1470.00

Procedure Codes	Code Description	Information	Fee Screen
D8070	Comprehensive orthodontic treatment of the transitional dentition	PA required only once; complete treatment plan required with time frame indicated. Maximum allowed for two-year period is \$3360.	Initial payment \$420
D8080	Comprehensive orthodontic treatment of the adolescent dentition	PA required only once; complete treatment plan required with time frame indicated. Maximum allowed for two-year period is \$3675.	Initial payment \$735
D8090	Comprehensive orthodontic treatment of the adult dentition	PA required only once; complete treatment plan required with time frame indicated. Maximum allowed for two-year period is \$3780.	Initial payment \$840
D8670	Periodic orthodontic treatment (as part of contract)	Periodic treatment visit—allowed quarterly for 2-year time period	\$420 ea.qtr.
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers)	PA required only once	\$210
D8692	Replacement of lost or broken retainer	PA required; limit of 2 allowed in two year period	\$78.50
D8999	Unspecified orthodontic procedure, by report	PA required; documentation required for services that do not fall within the parameters of the previous procedure codes	(manually priced)

### Manual Maintenance

Retain this Bulletin and the Dental Procedure Codes Appendix for future reference. Chapter V of the Dental Manual, Children’s Special Health Care Services, dated 10-27-1980 is obsolete.

**Draft**

MANUAL TITLE	<b>DENTAL</b>	PAGE <b>1</b>
APPENDIX TITLE	<b>DENTAL PROCEDURE CODES</b>	DATE

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/Number on Claim	Report Tooth Surface on Claim	Documentation Required w/ Claim
	<b>DIAGNOSTIC</b>							
	<b>CLINICAL ORAL EXAMINATIONS</b>							
D0120	Periodic (Recall) Oral Examination		X	X				
D0140	Limited Oral Evaluation-Problem-focused		X	X				
D0150	Comprehensive Oral Evaluation		X	X				
	<b>RADIOGRAPHS</b>							
D0210	Intraoral - complete series (including BW's)		X	X				
D0220	Intraoral first film periapical		X	X				
D0230	Intraoral-periapical, ea. additional film		X	X				
D0240	Intraoral-occlusal film		X	X				
D0270	Bitewing- single film		X	X				
D0272	Bitewing radiographs –two films		X	X				
D0274	Bitewing radiographs –four films		X	X				
D0330	Panoramic film		X	X				
D0340	Cephalometric Film	X						
	<b>PREVENTIVE</b>							
	<b>DENTAL PROPHYLAXIS</b>							
D1110	Adult Prophylaxis (age 14 and over)		X	X				
D1120	Child Prophylaxis (age 2-13)		X					
	<b>FLUORIDE TREATMENTS</b>							
D1203	Topical application of fluoride-child (age 2-17)		X					
	<b>SEALANTS</b>							
D1351	Sealants, per tooth (ages 5-15 only)		X			X		

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MANUAL TITLE	<b>DENTAL</b>	PAGE	<b>2</b>
APPENDIX TITLE	<b>DENTAL PROCEDURE CODES</b>		DATE

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/Number on Claim	Report Tooth Surface on Claim	Documentation Required w/ Claim
<b>SPACE MAINTAINERS</b>								
D1510	Fixed, unilateral band type (under age 13)		X					
D1515	Fixed, bilateral band type or palatal/lingual arch wire type (under age 13)		X					
D1550	Recementation of Spacer		X					
<b>RESTORATIVE TREATMENT</b>								
<b>AMALGAM RESTORATIONS</b>								
D2110	Amalgam - one surface, primary		X			X	X	
D2120	Amalgam - two surfaces , primary		X			X	X	
D2130	Amalgam - three surfaces, primary		X			X	X	
D2131	Amalgam - four or more surfaces, primary		X			X	X	
D2140	Amalgam - one surface, permanent		X	X		X	X	
D2150	Amalgam - two surfaces, permanent		X	X		X	X	
D2160	Amalgam - three surfaces, permanent		X	X		X	X	
D2161	Amalgam - four or more surfaces, permanent		X	X		X	X	
<b>RESIN RESTORATIONS</b>								
D2330	Resin - one surface, anterior		X	X		X	X	
D2331	Resin - two surfaces, anterior		X	X		X	X	
D2332	Resin - three surfaces, anterior		X	X		X	X	
D2335	Resin- based composite-four or more surfaces or involving incisal angle (anterior)		X	X		X	X	
D2336	Resin-based composite crown, anterior-primary		X			X		
D2337	Resin-based composite crown, anterior-permanent		X			X		
D2380	Resin, one surface, posterior - primary		X			X	X	

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PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/Number on Claim	Report Tooth Surface on Claim	Documentation Required w/ Claim
D2381	Resin, two surfaces, posterior - primary		X			X	X	
D2382	Resin, three or more surfaces – posterior- primary		X			X	x	
D2385	Resin, one surface, posterior - permanent		X	X		X	X	
D2386	Resin, two surfaces - posterior- permanent		X	X		X	X	
D2387	Resin, three surfaces-posterior- permanent		X	X		X	X	
D2388	Resin-based composite-four or more surfaces - posterior-permanent		X	X		X	X	
<b>CROWNS</b>								
D2710	Crown- Resin (laboratory)		X		X	X		
D2740	Crown-Porcelain/ceramic substrate	X			X	X		
D2750	Crown-Porcelain fused high noble metal	X			X	X		
D2751	Crown-Porcelain fused to predominantly base metal	X			X	X		
D2752	Crown-Porcelain fused to noble metal	X			X	X		
D2790	Crown-full cast high noble metal	X			X	X		
D2791	Crown-full cast predominantly base metal	X			X	X		
D2792	Crown-full cast noble metal	X			X	X		
<b>OTHER RESTORATIVE SERVICES</b>								
D2910	Recement Inlay		X	X		X		
D2920	Recement Crown		X	X		X		
D2930	Prefab. Stainless Steel Crown-primary		X			X		
D2931	Prefab. Stainless Steel crown-permanent		X			X		
D2933	Prefabricated stainless steel crown with resin window		X			X		

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MANUAL TITLE	<b>DENTAL</b>	PAGE	<b>4</b>
APPENDIX TITLE	<b>DENTAL PROCEDURE CODES</b>		DATE

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/Number on Claim	Report Tooth Surface on Claim	Documentation Required w/ Claim
D2940	Sedative filling		X			X		
D2950	Core Buildup, including any pins		X			X		
D2951	Pin retention-per tooth, addition to restoration		X	X		X		
D2952	Cast post and core in addition to crown		X			X		
D2954	Prefabricated post and core in addition to crown		X			X		
D2999	Unspecified restorative procedure, by report	X	X	X	X	X		X
	<b>ENDODONTICS</b>							
	<b>PULP CAPPING</b>							
D3110	Pulp cap - direct (excluding final restoration)		X			X		
	<b>PULPOTOMY</b>							
D3220	Therapeutic Pulpotomy (excluding final restoration) (under age 12)		X			X		
	<b>ROOT CANAL THERAPY</b>							
D3310	Anterior (excluding final restoration)		X			X		
D3320	Bicuspid (excluding final restoration)		X			X		
D3330	Molar root canal (excluding final restoration)		X			X		
D3351	Apexification-initial visit (under age 13)		X			X		
D3352	Apexification/recalcification –interim medication replacement (under age 13)		X			X		
D3353	Apexification-final visit (under age 13)		X			X		

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MANUAL TITLE	<b>DENTAL</b>	PAGE	<b>5</b>
APPENDIX TITLE	<b>DENTAL PROCEDURE CODES</b>		DATE

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/Number on Claim	Report Tooth Surface on Claim	Documentation Required w/ Claim
<b>PERIAPICAL SERVICES</b>								
D3410	Apicoectomy - anterior		X			X		
D3421	Apicoectomy – bicuspid (first root)		X			X		
D3425	Apicoectomy – molar (first root)		X			X		
D3426	Apicoectomy – (each additional root)		X			X		
D3430	Retrograde filling - per root		X			X		
D3999	Unspecified endodontic procedure, by report		X			X		X
<b>PERIODONTICS</b>								
D4341	Perio. Scaling and root planing (per quadrant)		X	X	X			
<b>PROSTHODONTICS, REMOVABLE</b>								
<b>COMPLETE DENTURES</b>								
D5110	Complete Denture-Maxillary		X	X	X			
D5120	Complete Denture-Mandibular		X	X	X			
D5130	Immediate Denture-Maxillary		X	X	X			
D5140	Immediate Denture-Mandibular		X	X	X			
<b>PARTIAL DENTURES</b>								
D5211	Maxillary partial denture, resin base		X	X	X			
D5212	Mandibular partial denture, resin base		X	X	X			
D5213	Maxillary partial denture, cast metal framework with resin denture bases		X	X	X			
D5214	Mandibular partial denture, cast metal framework with resin denture bases		X	X	X			
<b>ADJUSTMENTS</b>								
D5410	Complete denture adjustment -maxillary		X	X				

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APPENDIX TITLE	<b>DENTAL PROCEDURE CODES</b>		DATE

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/Number on Claim	Report Tooth Surface on Claim	Documentation Required w/ Claim
D5411	Complete denture adjustment -mandibular		X	X				
D5421	Partial denture adjustment - maxillary		X	X				
D5422	Partial denture adjustment - mandibular		X	X				
	<b>REPAIRS TO COMPLETE DENTURES</b>							
D5510	Repair broken complete denture base		X	X				
D5520	Replace missing or broken teeth-complete denture (each tooth)		X	X		X		
	<b>REPAIRS TO PARTIAL DENTURES</b>							
D5610	Repair resin denture base		X	X				
D5620	Repair cast framework		X	X				
D5630	Repair or replace broken clasp		X	X				
D5640	Replace broken teeth-per tooth		X	X		X		
D5650	Add tooth to existing partial denture		X	X		X		
D5660	Add clasp to existing partial denture		X	X				
	<b>DUPLICATION AND RELINING</b>							
D5710	Rebase complete maxillary denture		X	X				
D5711	Rebase complete mandibular denture		X	X				
D5720	Rebase maxillary partial denture		X	X				
D5721	Rebase mandibular partial denture		X	X				
D5730	Reline complete maxillary denture (chairside)		X	X				
D5731	Reline complete mandibular denture (chairside)		X	X				
D5740	Reline maxillary partial denture (chairside)		X	X				
D5741	Reline mandibular partial denture (chairside)		X	X				

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PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/Number on Claim	Report Tooth Surface on Claim	Documentation Required w/ Claim
D5750	Reline complete maxillary denture (laboratory)		X	X				
D5751	Reline complete mandibular denture (laboratory)		X	X				
D5760	Reline maxillary partial denture (laboratory)		X	X				
D5761	Reline mandibular partial denture (laboratory)		X	X				
<b>OTHER PROSTHETIC SERVICES</b>								
D5810	Interim complete denture (maxillary)		X		X			
D5811	Interim complete denture (mandibular)		X		X			
D5820	Upper denture, temporary, (partial- stayplate) Anterior-teeth only		X		X			
D5821	Lower denture, temporary, (partial-stayplate) Anterior-teeth only		X		X			
D5899	Not otherwise classified prosthetic procedures		X	X				X
<b>PROSTHODONTICS, FIXED</b>								
<b>BRIDGE PONTICS</b>								
D6210	Pontic –cast high noble metal	X			X	X		
D6211	Pontic-cast predominantly base metal	X			X	X		
D6212	Pontic-cast noble metal	X			X	X		
D6240	Pontic-porcelain fused to high noble metal	X			X	X		
D6241	Pontic-porcelain fused to predominantly base metal	X			X	X		
D6242	Pontic-porcelain fused to noble metal	X			X	X		
D6245	Pontic – porcelain/ceramic	X			X	X		
<b>CROWNS</b>								
D6740	Porcelain/ceramic	X			X	X		
D6750	Porcelain fused to high noble metal	X			X	X		

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PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/Number on Claim	Report Tooth Surface on Claim	Documentation Required w/ Claim
D6751	Porcelain fused to predominantly base metal	X			X	X		
D6752	Porcelain fused to noble metal	X			X	X		
D6790	Full cast - high noble metal	X			X	X		
D6791	Full cast- predominantly base metal	X			X	X		
D6792	Full cast - noble metal	X			X	X		
<b>OTHER FIXED PROSTHETIC SERVICES</b>								
D6930	Recement bridge		X	X				
D6970	Cast post and core in addition to fixed partial denture retainer	X			X	X		
D6971	Cast post as part of fixed partial denture retainer	X			X	X		
D6972	Prefabricated post and core in addition to fixed partial denture retainer	X			X	X		
D6973	Core build up for retainer, including any pins	X			X	X		
D6980	Fixed partial denture repair, by report	X			X			
<b>ORAL SURGERY</b>								
<b>SIMPLE EXTRACTIONS</b>								
D7110	Single tooth		X	X		X		
D7120	Each additional tooth		X	X		X		
<b>SURGICAL EXTRACTIONS</b>								
D7210	Extraction of tooth, erupted		X	X		X		
D7220	Extraction of tooth, soft tissue impaction		X	X		X		
D7230	Extraction of tooth, partial bony impaction		X	X		X		
D7240	Extraction of tooth, complete bony impaction		X	X		X		
D7250	Root recovery (surgical removal of residual root)		X	X		X		
<b>OTHER SURGICAL PROCEDURES</b>								

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PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/Number on Claim	Report Tooth Surface on Claim	Documentation Required w/ Claim
D7260	Oral antral fistula closure (and/or antral root recovery)		X	X				
D7270	Tooth replantation and/or stabilization		X			X		
D7280	Surgical exposure of impacted or unerupted tooth-simple	X				X		
D7281	Surgical exposure of impacted or unerupted tooth-complex	X				X		
D7310	Alveoplasty per quadrant, in conj. with extractions		X	X				
D7320	Alveoplasty per quadrant -not in conjunctions with extractions		X	X				
D7471	Removal of exostosis – per site		X	X				
D7510	Incision and Drainage (intraoral)		X	X				
D7970	Excision of hyperplastic tissue – per arch		X	X				
D7971	Excision of pericoronal gingiva		X	X				
D7999	Unspecified oral surgery procedure, by report		X	X				X
<b>ADJUNCTIVE GENERAL SERVICES</b>								
<b>UNCLASSIFIED TREATMENT</b>								
D9110	Palliative treatment		X					
<b>ANESTHESIA</b>								
D9220	General Anesthesia – first 30 minutes		X	X				X
D9221	General Anesthesia – each additional 15 minutes		X	X				X
D9241	IV Sedation/analgesia- first 30 minutes		X	X				X
D9242	IV Sedation/analgesia – each additional 15 minutes		X	X				X
<b>PROFESSIONAL VISITS</b>								
D9310	Consultation (service rendered by provider other than dentist providing treatment)		X	X				

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PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/Number on Claim	Report Tooth Surface on Claim	Documentation Required w/ Claim
D9420	Hospital Calls		X	X				
	<b>MISCELLANEOUS SERVICES</b>							
D9930	Complication (post surgical - unusual circumstances)		X	X				
	<b>ORTHODONTICS</b>							
D8050	Interceptive orthodontic treatment of the primary dentition	X			X			
D8060	Interceptive orthodontic treatment of the transitional dentition	X			X			
D8070	Comprehensive orthodontic treatment of the transitional dentition	X			X			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	X			X			
D8090	Comprehensive orthodontic treatment of the adult dentition	X			X			
	<b>OTHER ORTHODONTIC SERVICES</b>							
D8660	Pre-orthodontic treatment visit	X			X			
D8670	Periodic orthodontic treatment visit (as part of contract)	X			X			
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	X			X			
D8692	Replacement of lost or broken retainer	X			X			
D8999	Unspecified orthodontic procedure, by report	X			X			X