MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 05-45

Distribution: Dentists and Dental Clinics

Issued: October 1, 2005

Subject: Orthodontic Policy

Effective: November 1, 2005

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

Effective November 1, 2005, changes to the orthodontic procedure codes, prior authorization, and billing instructions for the Children's Special Health Cares Services (CSHCS) are implemented. Information regarding the medical criteria and qualifying diagnoses for specialty dental services, such as orthodontics, can be found in the CSHCS chapter of the Medicaid manual. The website address is: http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf The orthodontic procedure codes and descriptions are found within the American Dental Association's CDT procedure code manual. Information regarding the covered procedure codes for the CSHCS Program may be found on the Dental Procedure Code database at http://www.michigan.gov/documents/Dental_Database_2005_111781_7.pdf.

The pre-orthodontic evaluation and x-rays, including cephalometric x-rays, do not require prior authorization. The pre-orthodontic evaluation includes the exam and study models. The evaluation and x-rays are billed direct to the Michigan Department of Community Health (MDCH). All other orthodontic services require prior authorization.

Effective for dates of service on and after November 1, 2005, new prior authorization and billing instructions for interceptive and comprehensive orthodontic services are implemented.

Prior authorization for these services must be submitted prior to the initiation of treatment and placement of bands. Prior authorization for these services must be submitted in a timely manner. The prior authorization staff will consider retroactive prior authorization requests under special circumstances. A written explanation is necessary and must accompany the prior authorization request.

A prior authorization request is necessary for each stage of orthodontic treatment, such as interceptive or comprehensive treatment. For all requests, the box indicating the teeth that are present must be completed; an orthodontic treatment plan outlining the expected timeframe for completion, and information on the growth of the oral cavity must be included.

Interceptive orthodontic treatment codes should be used for procedures that lessen the severity or future effects of a malformation and to eliminate its cause. These procedures may involve non-surgical appliances used for palatal expansion. Other factors and conditions may require future comprehensive orthodontic treatment. Interceptive orthodontic treatment is a one-time prior authorization request for the entire timeframe of treatment. The fee for each interceptive orthodontic treatment phase is all inclusive. The banding/start date is to be used as the date of service on the claim form.

For example, when a provider requests D8050, interceptive orthodontic treatment of the primary dentition, the request must include the complete orthodontic treatment plan for the beneficiary and the timeframe to be completed. Upon submission of the claim, the provider will receive payment in full for the entire interceptive orthodontic treatment period.

Comprehensive orthodontic treatment codes are used when there are multiple phases of treatment provided at different stages of orofacial development that are non-surgical. Comprehensive orthodontic treatment services are covered for a lifetime maximum of six years, with each stage of dentition covered up to two years. The submission of the first prior authorization request for comprehensive orthodontic treatment should list the appropriate procedure code and the banding/start date of treatment. For each additional six-month time period, a separate prior authorization request for the periodic orthodontic treatment visit must be submitted indicating the proposed time period. The periodic orthodontic treatment visit procedure code may be used up to a total of four times per each comprehensive orthodontic treatment stage, if needed. When billing the periodic orthodontic treatment visit, the date of service begins the first day of the six-month time period. The entire time period should be entered into the Remarks section of the claim form.

When the provider enters into comprehensive orthodontic treatment, such as D8070 - comprehensive orthodontic treatment of the transitional dentition, the request must include the complete treatment plan, including proposed surgery, and the timeframe for the plan to be completed. The initial payment will be made with the comprehensive orthodontic procedure code for the banding/insertion date. The remaining payments will be reimbursed bi-annually using the periodic orthodontic treatment visit procedure code. A new prior authorization request is required for each six-month period of periodic orthodontic treatment. The original orthodontic treatment plan and prior authorization requests are kept on file with the MDCH Prior Authorization Unit.

If orthodontic treatment ends before a complete six-month time frame is completed, the provider should pro-rate the periodic orthodontic treatment fee for the treatment time frame. The periodic orthodontic treatment fee is based on a six-month time frame. If only three months are needed to complete treatment, then the fee charged should reflect half of the current periodic orthodontic treatment fee. For example, the current fee is $600, then the fee charged for three months of periodic orthodontic treatment should be half, or $300.

No initiation or initial banding/insertion of orthodontic treatment will be authorized if a prior authorization request is submitted less than 12 months prior to the 21st birthday of the beneficiary. No orthodontic treatment will be authorized for beneficiaries age 21 and over.

The retention procedure code D8680 is end-dated as of October 31, 2005. The debanding/retention is considered part of the orthodontic treatment plan. It is included in the fees of the periodic orthodontic treatment visit and interceptive orthodontic procedure codes.

Replacement of lost or broken retainers is allowed twice in a lifetime.

NOTE: For those cases already in treatment, when submitting a new prior authorization request for the periodic orthodontic treatment visit, please include the procedure code phase of treatment that the beneficiary is currently in on the prior authorization request form. This will help in reviewing case histories for determining the approval of future prior authorizations and the payment status of the beneficiary.

Also, for those cases already in treatment, no additional prior authorization requests will be approved if the amount already paid is equal to or more than the maximum allowable fee for that phase of treatment. If the case has already been paid up to the maximum fee screen, no additional monies will be paid and the case will be considered paid in full.

Below is the list of procedure codes and fee screens for orthodontic treatment.

D8660	Includes exam and study models	$107.09
D0340	Bill x-rays separately; no PA required	$28.39
D8050	PA required only once; payment in full upon submission of claim. Ages 0-9.	$1260
D8060	PA required only once; payment in full upon submission of claim. Ages 5-14.	$1470
D8070	PA required for the start of the stage of treatment; complete treatment plan required with timeframe indicated. Ages 5-14.	Initial $1460 Maximum allowed for two-year period is $3860

D8080	PA required for the start of the stage of treatment; complete treatment plan required with timeframe indicated. Ages 10-17.	Initial $1775 Maximum allowed for two-year period is $4175
D8090	PA required for the start of the stage of treatment; complete treatment plan required with timeframe indicated. Ages 17-20.	Initial $1880 Maximum allowed for two-year period is $4280
D8670	Periodic treatment visit—allowed bi-annually up to a two-year time period. Maximum allowable is four for each comprehensive stage.	$600
D8692	PA required; only 2 allowed per lifetime	$78.75
D8999	PA required; documentation required for services that do not fall within the parameters of the previous procedure codes	(manually priced)

MANUAL MAINTENANCE

The provider should retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

QUESTIONS

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

APPROVED

Paul Reinhart, Director
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