



Dental and Denturist Program

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Covered Services and Limitations

General Coverage Principles

Medicaid covers almost all dental and denturist services when they are medically necessary for clients under age 21. This chapter provides covered services information that applies specifically to dental and denturist services. Like all health care services received by Medicaid clients, these services must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information for Providers* manual.

The rules, regulations, and policies described in this manual apply to services provided by dentists, denturists, orthodontists, and oral surgeons. Providers may be reimbursed for Medicaid covered services when the following requirements are met:

- Provider must be enrolled in Medicaid. (ARM 37.85.402)
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law. (ARM 37.85.401)
- Client must be Medicaid eligible and non-restricted. (ARM 37.85.415)
- Service must be medically necessary. (ARM 37.85.410) (The Department may review medical necessity at any time before or after payment.)
- Service must be covered by Medicaid and not be considered cosmetic, experimental or investigational. (ARM 37.85.415)
- Charges must be usual and customary. (ARM 37.85.212)
- Claims must meet timely filing requirements. (ARM 37.84.406)
- Prior authorization requirements must be met. (ARM 37.86.1006)
- Passport approval requirements must be met.

Covered Dental Services

Full Medicaid

All clients under age 21 and some clients age 21 and over who have “Full” Medicaid coverage are eligible for only:

- diagnostic
- preventative
- basic restorative (including pre-fabricated stainless steel crowns)
- dentures (immediate, full and partial)
- and extraction services (ARM 37.86.1006)

Some “Full” Medicaid services are only available to those age 20 and under. Please review the most recent Department dental fee schedule for specific code coverage available for specific ages. Fee schedules are available on the Provider Information website (see Key Contacts).

Pregnant women who present a Presumptive Eligibility Notice of Decision. Providers should call 1-800-932-4453 to verify presumptive eligibility.

Basic Medicaid (37.85.206)

The **only** time clients who have “Basic” Medicaid benefits are eligible for dental coverage is when emergency dental services are necessary and when dental work is “essential for employment.”

Emergency dental services for adults ages 21 and over with “Basic” Medicaid (37.85.207)

Medicaid may cover emergency dental services for those clients who are on “Basic” Medicaid. Subject to the dental program limitations, the Medicaid program will reimburse dental providers for palliative treatment and diagnostic services related to the treatment of emergency medical conditions.

Emergency Dental Services means covered inpatient and outpatient services that are needed to evaluate and stabilize an emergency medical condition. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (included severe pain). Such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part. If the Medicaid professional rendering the medical screening deems an emergency dental condition does exist, stabilization treatment is rendered.

The following are acceptable dental emergency codes listed on the *Emergency Dental Services Form*. If the dental emergency treatment requires a code other than these, please indicate the code on the form and explain. Treatment may be approved if adequate documentation of the emergency treatment is provided on the form.

Emergency Dental Codes for Adults on Basic Medicaid					
D0140	D0273	D2161	D3346	D7270	D9420
D0220	D0274	D2330	D7140	D7510	D9612
D0230	D0275	D2331	D7210	D7520	D9920
D0240	D0277	D2332	D7220	D7910	
D0250	D0330	D2335	D7230	D9110	
D0260	D2140	D2940	D7240	D9241	
D0270	D2150	D3310	D7241	D9242	
D0272	D2160	D3331	D7250	D9248	

Preventative treatments or routine restorative services are excluded from emergency dental services under “Basic” Medicaid.

Emergency dental claims for adults 21 and over with “Basic” Medicaid must be accompanied by a completed Emergency Services Dental Form (see Appendix A: Forms).

- Routine restorative or preventive treatments are specifically excluded from any emergency dental services.
- Root canals are allowable on anterior teeth only.
- All other program limits still apply. RHCs and FQHCs will continue to bill revenue code 512 for these services.
- Document any delay between date of diagnosis and date of treatment. As a guideline, this time frame should be within 30 days of initial date of exam.
- Emergency dental claims for adults 21 and over on “Basic” Medicaid must be accompanied by a completed *Emergency Dental Services Form* (located in *Appendix A: Forms* and on the Provider Information website).

Essential for Employment Program (37.85.206)

In limited circumstances, Medicaid will cover a dental service normally excluded under “Basic” Medicaid if it is essential to obtaining or maintaining employment. When this is the case, the client will present a signed *Medicaid Services Essential for Employment Form* (DPHHS-HCS-782). Prior to receiving dental services as an *Essential for Employment* benefit, the client must obtain this form through their eligibility specialist at their local County Office of Public Assistance.

- Routine dental services (i.e., exam, x-rays and prophylaxis) are not covered services under the *Essential for Employment* program.
- Service/limitations, coverage, and reimbursement are the same for approved services as they would be for a “Full” Medicaid client.
- Claims must be accompanied by a completed *Medicaid Services Essential for Employment Form* (DPHHS-HCS-782), located in *Appendix A: Forms* and on the Provider Information website.

Access to Baby and Child Dentistry (ABCD)

The Access to Baby and Child Dentistry (ABCD) program was established to increase access to dental services for Medicaid-eligible children under age 6. ABCD focuses on preventive and restorative dental care for children from birth to age 6, with emphasis on the first dental appointment by age 1, if not sooner. It is based upon the premise that starting dental visits early will yield positive behaviors by both parents and children, thereby helping control the caries process and reduce the need for costly future restorative work.

Dentists must receive continuing education in early pediatric dental techniques to qualify as an ABCD specialist. This specialty endorsement will allow ABCD dentists to be reimbursed for the following procedures:

- D0145, Oral evaluation for a patient under 3
- D0425, Caries susceptibility test (age 0–3)
- D1310, Nutritional counseling (age 0–5)
- D1330, Oral hygiene instruction (age 0–5)

- Based upon the results of a caries risk assessment (CRA), each individual child will be determined either high risk or low/med risk. This is a result of measuring clinical conditions, environmental characteristics and general health conditions to document caries risk level. Risk level will determine visit frequency (up to three times per year for low/med risk, up to six times per year for high risk).
- The risk assessment shall be completed at each initial visit and annually thereafter up to age 3. Risk assessments are valid for one year.

ABCD Visit Frequency Related to Age and Level of Risk			
	<18m	>18m and <36m	>36m and <72m
Allowable Procedure Codes	D0145 D0425 D1206 D1310 D1330	D0145 D0425 D1206 D1310	D0150 D1120 D1206 D1330
Low/Medium Risk	Up to three/year	Up to three/year	Up to three/year
High Risk	Up to six/year	Up to six/year	Up to three/year

Family oral health education is a strong component of this program. This is completed at the dental office. Other components of the program include proper training in oral hygiene techniques and the application of fluoride varnish. Restorative and radiographic services are used as determined necessary by the dentist.

Tamper-resistant prescription pads

As of October 1, 2008, all fee-for-service Medicaid prescriptions that are either handwritten or printed from an EMR/ePrescribing application must contain **three different tamper-resistant features**, one from each of the three categories described below. Feature descriptions:

- One or more industry recognized features designed to prevent unauthorized copying of a completed or blank prescription.
- One or more industry recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.
- One or more industry recognized features designed to prevent the use of counterfeit prescriptions.

Prescriptions for Medicaid patients that are telephoned, faxed or e-Prescribed are exempt from these tamper-resistance requirements.

Non-Covered Services

1. ***Porcelain/ceramic crowns, noble metal crowns and bridges are not covered for clients 21 years of age and older.***

2. ***No-show appointments.*** A “no-show” appointment occurs when a client fails to arrive at a provider's office for a scheduled visit and did not cancel or reschedule the appointment in advance. “No-show” appointments are not a covered service and cannot be billed to Medicaid.
3. ***Cosmetic dentistry.*** Medicaid does not cover cosmetic dental services.
4. ***Splints/mouthguards.*** Splints and mouth guards for clients 21 years of age and older are not a covered service of the Medicaid program.
5. ***Qualified Medicare Beneficiary (QMB).*** Medicaid does not cover dental services for clients that have “QMB” on their Medicaid eligibility information. See the *General Information For Providers* manual, *Client Eligibility and Responsibilities* chapter for more information on QMB.
6. ***Basic Medicaid Coverage.*** Dental services are not covered for clients that have “Basic” on their Medicaid eligibility information. However, the client may be eligible for emergency dental services and/or when dental work is *Essential for Employment*. See *Who is eligible for dental services?* at the beginning of this chapter.)
7. ***Dental implants***

Coverage of Specific Services (ARM 37.86.1006)

Medicaid allowable procedure codes and limitations can be found on-line under Fee Schedules. Please use the ADA CDT resource for a complete description of each code.

Diagnostic

The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis, and treatment planning are the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners or specialists.

- Examinations for adults will be allowed every six months or more often if a referral has occurred. If both the dentists involved in the referral have done full exams, both can be paid. For this exception to be made, the providers must both indicate on their claims that a referral has occurred and the name of the other dentist involved. This information should be reported in the remarks section of the claim form. If you have a denial of the referral visit, please review your claim to ensure you have the referring dentist's name and resubmit for payment. If you have a copy of your claim and the referring dentist's name is listed, please call Provider Relations (see *Key Contacts*) for a request to reprocess this claim.
- Exams, x-rays, and prophylaxis are not covered for adults on Basic Medicaid who qualify for the Essential for Employment program.



Medicaid allowable procedure codes and limitations can be found online under Fee Schedules. Please use the ADA CDT resource for a complete description of each code.

Radiographs

Radiographs should be taken only for clinical reasons as determined by the client's dentist. They should be of diagnostic quality, properly identified and dated. They are considered to be part of the client's clinical record.

If additional panoramic films are needed for medical purposes (i.e., to check healing of a fractured jaw), they can be billed on an ADA form (2006) as long as it was done in an office setting. Otherwise, they should be billed on the CMS-1500 (formerly HCFA-1500) claim form using the CPT Code 70355 for panoramic x-ray. Exams, x-rays, and prophylaxis are not covered for adults on Basic Medicaid who qualify for the Essential for Employment program.

When more than one film has been taken, add the number of units in the description box and multiply the fee by the units in the fee box.

Preventive

Prophylaxis and fluoride treatments are allowed every six months.

- If providers are treating individuals with a developmental disability who require a prophylaxis treatment more often than six months intervals, indicate "Developmentally Disabled" in the remarks section of the ADA claim form.
- Billed code choices of adult or child prophylaxis are up to the professional expertise of the provider (i.e., D1110, D1120, D1203, D1204).
- Exams, x-rays, and prophylaxis are not covered for adults on Basic Medicaid who qualify for the Essential for Employment program.
- Physicians (only) will be reimbursed by Montana Medicaid for applying fluoride varnish (Code D1206) to children under age 21 at well-child appointments. Physicians are encouraged to make referrals when appropriate in an effort to help the child establish a dental home. Physicians should bill Code D1206 on a CMS-1500 claim form. If the child is determined high-risk for early childhood caries, up to six treatments per year will be allowed.

Restoration

Fillings

For complete restoration of a tooth (filling of all surfaces currently damaged by caries), the following policies apply:

- When more than one surface is involved, and one continuous filling is used, select the appropriate code from the range of D2140 through D2394.
- When there are separate fillings on each surface, the one-surface codes (D2140 and D2330) are to be used. Your records must clearly indicate each filling is treatment for a separate cavity.
- The ADA views restorative work done on the same day and same tooth as one tooth with five surfaces.



When more than one film has been taken, add the number of units in the description box and multiply the fee by the units in the fee box.

- Only one payment will be allowed for each surface.
- When more than one filling is included on a surface, combine the code. For example, MO and LO on a permanent molar restored in the same day should be coded as MOL. This should be coded this way whether the filling on the occlusal is a continuous filling or two separate fillings. The ADA views work done on the occlusal as one of the five surfaces that are billable.
- When more than one filling is included on a surface and restored on different days, they should be coded on different days. For example, if MO and LO on a permanent molar are restored on subsequent days, they should be coded as a MO on the first day and LO on the second day.
- **Amalgam restorations (including polishing).** All adhesives (including amalgam bonding agents), liners, and base are included as part of the restoration. If pins are used, they should be reported separately (see Procedure Code D2951).
- **Silicate and resin restorations.** Resin refers to a broad category of materials including, but not limited to, composites. Also included may be bonded composite, light-cured composite, etc. Light-curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. If pins are used, they should be reported separately (see Procedure Code D2951).

Crowns

Crowns are covered only for clients with “Full” Medicaid coverage. Crowns are limited to situations where the tooth is periodontally healthy and without pulpal pathology and the tooth cannot be restored by any means other than a full coverage restoration.

- **Prefabricated Crowns.** Prefabricated stainless steel and prefabricated resin crowns D2930–D2933 are available for all clients, regardless of age and regardless of tooth number. There is a limit for crowns of one per tooth, every five years.
- **All Other Crowns – Porcelain/Ceramic, High Noble Metal, Non-Prefab, Highmetal, Gold, Porcelain.** All crowns, other than prefabricated stainless steel and prefabricated resin, are only available to “Full” Medicaid clients age 20 and under. Porcelain or ceramic crown restorations are only available for anterior teeth (6-11 and 22-27). Generally, crowns on posterior teeth are limited to pre-fabricated resin and/or pre-fabricated stainless steel, except when necessary for partial denture abutments. Indicate in the “Remarks” section of the claim form which teeth are abutment teeth. Crowns are limited to one per tooth every five years.

- Expanded coverage is available for procedure codes D2751, D2781 and D2791 (porcelain fused to base metal crowns) for anterior or posterior teeth following approval through the prior authorization process. These codes are open to children and adults on Full Medicaid and adults approved under the Essential for Employment program. Crown code D2750 (porcelain with high noble metal) is now allowed for children under 21 years of age for posterior teeth with prior authorization. For D2750, the prior authorization request must show a definitive medical need for a high noble metal versus porcelain fused to base metal crown. For D2751, D2781 and D2791, the prior authorization request must show a definitive medical need for porcelain fused to base metal crown versus pre-fabricated stainless steel crown.
- **Dental services – crowns.** Limits have been established for adults age 21 and over for porcelain fused to base metal crowns (D2751) with prior authorization, limited to two per person per calendar year, total. Second molars (2, 15, 18, and 31) will receive base metal crowns only (D2791).

Endodontics

Canal therapy includes primary teeth without succedaneous teeth and permanent teeth.

- ***Complete root canal therapy.*** Pulpectomy is part of root canal therapy (dental pulp and root canal are completely removed). It includes all appointments necessary to complete treatment and intra-operative radiographs. It does not include diagnostic evaluation and necessary radiographs/diagnostic images.
- Pulpotomy (pulp tissue in crown removed, but tissue in root canal remains) (covered for ages 20 and under only) cannot be billed on the same day as endodontic therapy for the same tooth. Per guidance from the American Dental Association coding department, Code D3220 should never be billed if a root canal is to be performed by the same provider.

Periodontics

- ***Apicoectomy/periradicular services (ages 20 and under only).*** Periradicular surgery (removal of root top after root canal) is a term used to describe surgery to the root surface such as apicoectomy, repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement.

- ***Gingivectomy/plasty per quadrant.*** Gingivectomy/plasty per quadrant is limited to cases involving gingival hyperplasia due to medication reaction or pregnancy. One quad equals one unit of service. Per quadrant should be listed in the “Tooth Number” column as follows:
 - LL – Lower Left
 - UL – Upper Left
 - LR – Lower Right
 - UR – Upper Right
- ***Full mouth debridement.*** Full mouth debridement is to be used prior to periodontal scaling and root planning only if the provider cannot determine the extent of periodontal scaling and root planning without this procedure. It is limited to one time per year if medically indicated. If providers are treating individuals with a developmental disability who require this treatment more often than once a year, indicate “Developmentally Disabled” in the remarks section of the ADA claim form.

Prosthodontics, removable

This services is available to clients of all ages with “Full” Medicaid. A partial denture five years or older may be replaced by full and/or partial dentures. Full dentures, ten years old or older, may be replaced when the treating dentist documents the need for replacement. Payment for the denture includes payment for any tissue conditioners provided. Payment for denture adjustments during the first year after delivery of the dentures is available only to a dentist or denturist who did not make the dentures. The first three adjustments after dentures are placed are included in the denture price. Complete and partial dentures include routine post delivery care. **Call Provider Relations to verify if a client is eligible for a new denture or replacement for a lost one (see *Key Contacts*).**

Medicaid will replace lost dentures for eligible clients with a lifetime limit of **one** set. The claim form must include the age of the lost dentures and the term “Lost Dentures” written in the remarks section of the claim.

A dentist’s prescription is required and must be kept in the client file in the following circumstances:

- All partial denture work
- All immediate denture work

Limitations or requirements for the dental codes are listed with the procedure codes on the fee schedule.

No prescription is necessary when a new patient requires repairs to existing dentures or partials.



A dentist's prescription is required for all partial and immediate denture work.



Fixed prosthodontics services are only available to clients age 20 and under.

The above limits may be exceeded when the dentist and the Department consultant agree the current dentures are causing the client serious physical health problems. In these situations, the provider should submit a prior authorization request. See the *Prior Authorization* chapter in this manual.

Denture billing date

Dentures must be billed using the date of service the client receives the dentures. The only exception is when the client is not eligible on the date of service, then the date of impression may be used.

Prosthodontics, fixed

These services are only available to clients age 20 and under. Tooth colored, fixed partial denture pontics are only available for anterior teeth (6-11 and 22-27). Fixed partial denture pontics are not allowed for posterior teeth unless used to replace an anterior tooth. As an example, if tooth number 6 is missing, the fixed denture pontic will cover teeth numbers 5–7. In this example, tooth number 5 can be tooth colored. In cases where a posterior tooth is to be replaced, a partial denture must be used. Please review Item 6, *Prosthodontics, removable* for information regarding partial dentures. Fixed partial denture pontics are limited to one every tooth, every five years.

Oral surgery

Impacted third molars or supernumerary teeth are covered only when they are symptomatic; that is, causing pain, infected, preventing proper alignment of permanent teeth or proper development of the arch.

Providers may use current CPT procedure codes for **medical** services provided in accordance of practice permitted under state licensure laws and other mandatory standards applicable to the provider. Medical services are those that involve the structure of the mouth (i.e., jaw bone). Any services involving the tooth, are considered **dental** services. Medical services can be billed on an ADA form as long as the services were provided in an office. If the procedures were done in a hospital or nursing facility setting, they must be billed on the CMS-1500 (formerly HCFA-1500) claim form with valid CPT procedure codes and valid ICD-9-CM diagnosis codes. Providers who frequently bill for medical services should obtain a copy of the *Physician Related Services* manual. This manual is available on the Provider Information website (see *Key Contacts*).

These procedures will be reimbursed through the resource based relative value scale (RBRVS) fee schedule. All current CPT codes billed will comply with rules as set forth in the Administrative Rules of Montana (ARM) for physicians. General anesthesia is listed in the current CPT procedures codes and must be billed using a CMS-1500 (formerly HCFA-1500) claim form.



Surgical extractions include local anesthesia and routine postoperative care.

Orthodontics

See the *Orthodontia Services and Requirements* chapter in this manual for more information on covered orthodontia services and limitations.

Date of Service

Date of service is the date a procedure is completed. However, there are instances where Medicaid will allow a date other than the completion date.

Dentures must be billed using the date of service the client receives the dentures. The only exception is when the client is not eligible on the date of service, then the date of impression may be used.

If a crown or bridge has been sent to the laboratory for final processing, and the client never shows for the appointment to have the final placement, providers may bill the date of service as the date the crown or bridge was sent to the laboratory for final processing. However, the client must have Medicaid eligibility at the time the crown or bridge is sent to the lab. Bridges are limited to clients age 20 and under. All crowns other than pre-fabricated stainless steel and pre-fabricated resin are only available to clients with “Full” Medicaid coverage age 20 and under.

If a provider has opened the area for a root canal but anticipates the client will not return for completion or is referring client to another provider for root canal completion, procedure D3220 (covered for ages 20 and under only) may be billed. However, root canal codes must be billed to Medicaid at the time of completion.

Fee Schedule

All procedures listed in the Montana Medicaid Fee Schedule are covered by the Medicaid program and must be used in conjunction with the limits listed in this manual. If current CDT codes exist and are not listed in the Montana Medicaid Fee Schedule, the items are not a covered service of the Medicaid program. Services that are not covered or exceed the specified limits can be billed to the client as long as the provider informs the client, prior to providing the services, that the client will be billed and the client agrees to be private pay. Fee schedules are available on the Provider Information website or hardcopy from Provider Relations (see *Key Contacts*).

Calculating Service Limits

Any service which is covered only at specified intervals for adults will have a notation next to the procedure code with information about the limit in the *Coverage of Specific Services* section of this chapter. When scheduling appointments, please be aware limits are controlled by our computerized claims payment system in this manner. Limits on these services are controlled by matching the date on the



Service limits do not apply to individuals up to and including age 20.

last service against the current service date to assure the appropriate amount of time (six months, one year, or three years) has elapsed. Procedure codes that have limits are described on the fee schedule.

For example, if an adult received an examination on February 27, and the same service was provided again on February 26 of the following year, the claim would be denied as a complete year would not have passed between services. If the service were provided on February 27 of the following year, or after, it would be paid.

Providers should call Provider Relations (see *Key Contacts*) to get the last date of service for those procedure codes with time limits or other limitations of dental services. This information will allow the provider to calculate service limitations, but it does not guarantee payment of service for service-limited procedures. In certain circumstances, prior authorization may be granted for services when limits have been exceeded. See the *Prior Authorization* chapter in this manual.

EPSDT Services for Individuals Age 20 and Under

Limits on medically necessary services (e.g., exams, prophylaxis, x-rays, etc.) do not apply to clients age 20 and younger as part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. Medicaid has a systematic way of exempting children from the service limits. Therefore, providers no longer need to indicate “EPSDT” on the claim form for the limits to be overridden.

If you are providing a procedure not listed in the Montana Medicaid fee schedule to a child and it is medically necessary, please contact the Dental Program Officer (see *Key Contacts*) for claims processing instructions.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

Healthy Montana Kids (HMK)

The information in this chapter does not apply to HMK clients. Dental services for children with HMK coverage are covered by the HMK plan of Blue Cross and Blue Shield of Montana (BCBSMT). For more information contact BCBSMT at 1-877-543-7669. Additional information regarding HMK is available on the HMK website (see *Key Contacts*).

Orthodontia Services and Requirements

There are numerous types of congenital craniofacial anomalies, the most common of which is cleft lip and/or palate. In the United States this birth defect affects approximately one in 450 newborns each year. Approximately one-half of these infants have associated malformations, either major or minor, occurring in conjunction with the cleft.

The health and well being of these children is dependent upon the clinical expertise of those who serve them. The American Cleft Palate/Craniofacial Association has developed a list of fundamental principles regarding the optimal care of clients with craniofacial anomalies, regardless of the specific type of disorder. The following are included:

- Management of clients with craniofacial anomalies is best provided by an interdisciplinary team of specialists.
- Treatment plans should be developed and implemented on the basis of team recommendations.
- Care should be coordinated by the team but should be provided at the local level whenever possible. However, complex diagnostic and surgical procedures should be restricted to major centers with the appropriate facilities and experienced care providers.
- It is the responsibility of each team to monitor both short-term and long-term outcomes. Thus, longitudinal follow-up of clients, including appropriate documentation and record keeping, is essential.

Orthodontia services and limitations

Medicaid and Children's Special Health Services (CSHS) will cover eligible children in need of orthodontic treatment for a medical condition with orthodontia implications. Eligible children will be referred to a regional Cleft/Craniofacial Clinic for orthodontic evaluation. Medicaid eligible children in need of orthodontic treatment due to anomalies (category A) will participate in the CSHS Clinic program and Medicaid will pay for orthodontic services under the conditions listed below.

Category A Criteria

Orthodontic services needed as part of treatment for a medical condition with orthodontia implications including but not limited to the following conditions:

- Chromosomal syndromes with intact neuro-developmental status*
- Syndromes affecting bone
- Syndromes of abnormal craniofacial contour

- Syndromes with craniosynostosis
- Proportionate short stature syndromes
- Syndromes of teratogenic agents
- Deformations and disruptions syndromes
- Syndromes with contractures
- Branchial arch and oral disorders
- Overgrown syndromes, postnatal onset syndromes
- Hamartoneoplastic syndromes
- Syndromes affecting the central nervous system
- Orofacial clefting syndromes
- Syndromes with unusual dental acral findings
- Syndromes affecting the skin and mucosa
- Syndromes with unusual facies
- Syndromes gingival/periodontal components
- Malocclusion resulting from traumatic injury

*Chromosomal syndromes with a neurological component that precludes optimal outcome must have prior approval by the Cleft/Craniofacial quality assurance panel prior to authorization of payment.

Taken From: *Syndromes of the Head and Neck*, Gorlin, Cohen, Jr., Levin Oxford Press, 1990

When a Cleft/Craniofacial Team determines that a client is in Category A, CSHS, through regional Clinic coordinators, will assume the role of providing integrated care coordination through referral to local agencies. This will assure quality and continuity of client care and longitudinal follow-up. Each client seen by the team requires comprehensive, interdisciplinary treatment planning to achieve maximum results with efficient use of parent and client time and resources. (For specific responsibilities of CSHS and the team related to integrated case management refer to pages 7–9 of *Parameters for Evaluation and Treatment of Clients with Cleft Lip/Palate or Other Craniofacial Anomalies*, an official publication of the American Cleft Palate-Craniofacial Association published in March 1993.)

Category B Criteria

Interceptive orthodontic services (Category B) will be funded for Medicaid eligible children only. Category B services are limited to Medicaid eligible children 12 years of age or younger with one or more of the following condition(s):

- Posterior crossbite with shift (bilateral)
- Anterior crossbite

CSHS will not fund orthodontia for children in Category B.

Referral

All Medicaid/Children's Special Health Services (CSHS) eligible children (clients) needing orthodontic treatment will be referred as follows:

- For those eligible children needing orthodontia that qualify under Category A with a cleft/craniofacial condition, contact CSHS at (406) 444-3622 for referral to a regional Cleft/Craniofacial Clinic for evaluation. Complete form Ortho1 (located in Chapter 3, *Prior Authorization*) and submit to SHS (see *Category A protocol*).
- For those eligible children needing orthodontia who may qualify under Category A with a possible cleft/craniofacial condition or syndrome with orthodontic implications, contact CSHS at (406) 444-3622, to request a regional Cleft/Craniofacial Clinic screening.
- For those eligible children that qualify under Category B, complete form Ortho1 (located in Chapter 3, *Prior Authorization*) and submit to Claims Processing Unit (see *Key Contacts*) X-rays, molds, and/or photographs must also be included in order to complete the review.
- For those eligible children with malocclusion resulting from traumatic injury complete form Ortho1 (located in Chapter 3, *Prior Authorization*) and submit to Claims Processing Unit (see *Key Contacts*). Evaluation and management by a cleft craniofacial team is not required.
- For those eligible children that do not meet Category A or B, orthodontia services are not a covered benefit of the Medicaid Program or Children's Special Health Services Program. For questions regarding non-coverage contact: provider hotline 1-800-480-6823; client hotline 1-800-362-8312.

Orthodontia procedure limits and requirements

The codes listed below only include procedures that have a descriptive limitation or requirement. See the ADA CDT practical guide for further details.

Code	Procedure Description	Limitation or Requirement
D8050	Interceptive orthodontic treatment of the primary dentition	The treatment plan form (Ortho 1) required for PA approval is at the end of Chapter 3, <i>Prior Authorization</i> .
D8060	Interceptive orthodontic treatment of the transitional dentition	The treatment plan form (Ortho 1) required for PA approval is at the end of Chapter 3, <i>Prior Authorization</i> .
D8070	Comprehensive orthodontic treatment of the transitional dentition	The treatment plan form (Ortho 1) required for PA approval is at the end of Chapter 3, <i>Prior Authorization</i> .
D8080	Comprehensive orthodontic treatment of the adolescent dentition	The treatment plan form (Ortho 1) required for PA approval is at the end of Chapter 3, <i>Prior Authorization</i> .
D8090	Comprehensive orthodontic treatment of the adult dentition	The treatment plan form (Ortho 1) required for PA approval is at the end of Chapter 3, <i>Prior Authorization</i> .
D8670	Periodic orthodontic treatment visit (as part of contract)	The treatment plan form (Ortho 1) required for PA approval is at the end of Chapter 3, <i>Prior Authorization</i> .
D8680	Orthodontic retention	The treatment plan form (Ortho 1) required for PA approval is at the end of Chapter 3, <i>Prior Authorization</i> .

Category A Protocol

1. All Medicaid/Children's Special Health Service (CSHS) clients must be followed by a Cleft/Craniofacial Team according to the team's recommended schedule. The composition of team members staffing the Clinic will be determined by CSHS.
2. All eligible clients must have a current treatment plan (form Ortho 1 in Chapter 3, *Prior Authorization*) completed for authorization of care by the treating orthodontist.
3. The plan will include the following information: Documentation of oral hygiene status, recommended phases of treatment, appliances or therapies, if applicable, at each phase and the estimated time and cost of each phase.
4. The treatment plan will be updated when a client completes a phase of treatment prior to authorization of payment for the next phase of treatment.
5. Clients included within Category A requiring orthodontic treatment, as determined by the team, will be referred to a Board-certified or Board-eligible orthodontist for orthodontic treatment. Some phases of treatment may be completed by a pediatric dentist when appropriate, until a child reaches age 10, and as part of the approved orthodontic plan.
6. CSHS will review the treatment plan for each client, and complete the following:
 - Review of initial and updated plans for orthodontic treatment. If questions arise after consultation with the provider, a member of the quality assurance panel for CSHS Cleft/Craniofacial teams will review the plan.
 - Review requests of providers for changes in treatment plan and reimbursement due to unforeseen treatment complications. Deviation from the contract regarding cost or length of treatment phases after consultation with the providers will be referred to a member of the CSHS Cleft/Craniofacial quality assurance panel.
 - Authorization of orthodontia treatment
7. Completed treatment plans will be submitted to: CSHS, P.O. Box 202951, 1400 Broadway, Helena, MT 59620.
8. Medicaid clients, who are currently receiving orthodontic treatment or have authorization for treatment prior to the effective date of the protocol, will **not** be included in this plan unless agreed to by Medicaid/CSHS.

9. Treatment plans submitted to CSHS for Non-category A Medicaid-eligible children will be forwarded to the Medicaid dental/orthodontia program for review by Medicaid orthodontia consultant for determination of qualifying for interceptive orthodontia services under Category B.
10. This protocol will be reviewed and revised upon agreement between Children's Special Health Services and Medicaid.

Category B Protocol

1. All Medicaid clients must have a treatment plan (form Ortho1 in Chapter 3, *Prior Authorization*) completed and submitted to the Claims Processing Unit (see *Key Contacts*). Prior authorization must include the following information:
 - Documentation of oral hygiene status
 - Appliances or therapies
 - Number of treatment months requested
 - The estimated time and cost of the service
 - X-rays, molds, and/or photographs must also be included to allow prior authorization determination completion.
2. Clients included within Category B requiring interceptive orthodontic treatment as determined by the department's designated peer reviewer, may be treated by a licensed dentist.
3. Any deviation from the treatment plan as initially submitted regarding cost or length of time will be referred to the department's designated peer reviewer for further review.
4. Montana Medicaid will pay per procedure code based on the fee-for-service schedule. This reimbursement includes the appliance, follow-up visits and removal of the appliance.

General Considerations

- There is a fee cap of \$7000 for orthodontic treatment.
- Payment for orthodontic services will not be authorized without documentation of oral hygiene and dental health status. (See treatment plan for criteria.)
- Reimbursement will be based on the current fee-for-services schedule.
- Providers should be aware that in the event a client is no longer eligible for Medicaid/CSHS, the parent or guardian assumes responsibility for the remainder of the balance.

Non-covered services

- Cosmetic orthodontics is **not** a benefit of the Medicaid program.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

Healthy Montana Kids (HMK)

The information in this chapter does not apply to HMK clients. Dental services for children with HMK coverage are covered by the HMK plan of Blue Cross and Blue Shield of Montana (BCBSMT). For more information, contact BCBSMT at 1-877-543-7669. Additional information regarding HMK is available on the HMK website (see *Key Contacts*).

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