Agenda

Medicaid Orthodontic Stakeholder Meeting

Friday, January 9, 2009
9:00 – 11:30 am
Texas Dental Association Building
Executive Board Room, Suite 400
1946 S. IH-35
Austin, Texas 78704

Agenda topics

- Welcome and Introductions
- Review and discussion of Draft Outlines
  - Cleft/Craniofacial/Syndromic and High-Level
  - THSteps Orthodontic Policy
- Review of Benefit Implementation Process
- Next Steps
- Adjourn

Proposed Definition of Handicapping Malocclusion: Compromised masticatory function as a result of the existing relationship between the maxillary and mandibular dental arches.

1. Provider Types:

- A) Dentists who are orthodontic board certified or orthodontic board eligible
- B) Dentists doing limited orthodontics

Note: First submitted case for prior authorization following implementation of revised orthodontic policy must include documentation of one of the following:

- Orthodontic board certification
- Eligibility for orthodontic board certification
- Pediatric dental residency completion
- Minimum of 200 hours of continuing dental education in orthodontics

2. Types of Service:

- Tier I – Mid-level handicapping malocclusion – major – potential surgical approach.
    - Semi-functional full Class II bite relationship
    - Semi-functional full Class III relationship
    - Cuspid crowding – if a cuspid is blocked out and only 4 mm or less space exists for the cuspid to erupt into.
    - Anterior openbite – maxillary and mandibular central and lateral incisors do not occlude in centric relation with a 1 mm or greater space.
    - Posterior openbite – bicuspids and/or molars are vertically separated by 1 mm or greater space in centric relation. (Note: This separation is usually caused by a lateral tongue thrust and is not to be confused with normal eruption of teeth.)
    - Crossbites – buccal or lingual, anterior or posterior.
    - Impacted teeth – excluding third molars.
    - Overbite – 6 mm or greater.
    - Overjet – 7 mm or greater.
    - **Requirements:**
        - Limited to orthodontic board certified and orthodontic board eligible dentists; and,
        - Consultation with oral surgeon and preliminary surgical treatment plan documented on prior authorization form if surgical intervention considered.

- Tier II – Low-level handicapping malocclusion – four (4) or more of the following conditions must be present to qualify for consideration of orthodontic treatment as a handicapping malocclusion.

Please note: Each condition is counted as one (1) discrepancy and not two (2) or three (3) of the same discrepancy. Functional discrepancies must be documented to support consideration of orthodontic treatment as a handicapping malocclusion.

  - Partial Class II – the mesiobuccal cusp of the maxillary first molar is 2 mm mesial from it's Class I relationship with the mandibular first molar in centric relation.
  - Partial Class III – the mesiobuccal cusp of the maxillary first molar is 2 mm distal from it's Class I relationship with the mandibular first molar in centric relation.
  - Class II Cuspid relationship – If the cusp of the maxillary cuspid extends mesially towards a Class II relationship by 3 mm as measured from the distal of the mandibular cuspid.
  - Overbite – 4 mm or greater
  - Overjet – 4.5 mm or greater
  - Crowding of mandibular anterior teeth – 4.5 mm or greater
  - Maxillary peg laterals
  - Congentially missing teeth
  - Midline discrepancy – 2 mm or greater
  - Division 2 maxillary anterior relationship
  - Maxillary diastema – 2mm or greater
  - Generalized spacing in the upper arch – 5 mm or greater
  - Generalized spacing in the lower arch – 5 mm or greater
  - No overbite – end-to-end anterior relationship
  - **Requirements:**
    - Orthodontic board certified and orthodontic board eligible dentists; or,
    - Completion of pediatric dental residency; or,
    - Documentation of completion of 200 or more hours of continuing dental education in orthodontics.

- Tier III – Interceptive orthodontics of the transitional dentition
  - D8060
    - Palatal or mandibular expansion
    - Crossbite correction
  - D8210 or D8220
    - Treatment to control harmful habits
      - Tongue thrust
      - Thumb sucking

- **Requirements:**
  - Orthodontic board certified and orthodontic board eligible dentists; or,
  - Completion of pediatric dental residency; or,
  - Documentation of completion of 200 or more hours of continuing dental education in orthodontics.

3. Prior Authorization Submission Requirements:

- **Tier I Orthodontic Cases – possible surgical approach**
  - Completion of THSteps Orthodontic Treatment Plan Prior Authorization – Surgical form
    - Treatment plan must be signed by submitting orthodontist or dentist and parent/guardian
    - Consultation with oral surgeon and preliminary surgical treatment plan documented on prior authorization form if surgical intervention is considered
  - Radiographs
    - Panoramic
    - Cephalometric with tracings
    - Note: A 2-D or 3-D CT Scan can be substituted for the panoramic radiograph
  - Photographic images (8-9)
    - Must include full face smiling, left and right profiles, full maxillary arch, full mandibular arch, right side occluded in centric relation, left side occluded in centric relation
    - Note: Photographic images must be taken in a 1:1 ratio format
  - Written narrative documenting functional discrepancies that support handicapping malocclusion classification

- **Tier II – Low-level handicapping malocclusion – four or more minor conditions**
  - Completion of THSteps Orthodontic Treatment Plan Prior Authorization – Non-Surgical form
    - Treatment plan must be signed by submitting orthodontist or dentist and parent/guardian
  - Radiographs
    - Panoramic
    - Cephalometric with tracings
    - Note: A 2-D or 3-D CT Scan can be substituted for the panoramic radiograph
  - Photographic images (8-9)
    - Must include full face smiling, left and right profiles, full maxillary arch, full mandibular arch, right side occluded in centric relation, left side occluded in centric relation

        - Note: Photographic images must be taken in a 1:1 ratio format
    - Written narrative documenting functional discrepancies that support handicapping malocclusion classification

- **Tier III – Interceptive Orthodontic Cases**
    - Completion of THSteps Orthodontic Treatment Plan Prior Authorization – Non-Surgical form
        - Treatment plan must be signed by submitting orthodontist or dentist and parent/guardian
    - Radiographs
        - Panoramic
        - Cephalometric with tracings
    - Photographic images (8-9)
        - Must include full face smiling, left and right profiles, full maxillary arch, full mandibular arch, right side occluded in centric relation, left side occluded in centric relation
        - Note: Photographic images must be taken in a 1:1 ratio format

4. Pricing Assumptions for Consideration:

	Tier I	Tier II	Tier III
Records	X	X	X
• Work up (photos, x-rays, models, treatment plan preparation)	X	X	X
• Mid-treatment (photos, x-rays, models)	X		
• Final (photos, x-rays, models)	X	X	X
Banding (maxillary and mandibular arches)	X	X	
Appliance(s) for treatment			X
Periodic Orthodontic Visits	X (36)	X (24)	X (6)
Debanding	X	X	
Retention	X	X	X

5. Payable CDT Codes:

- D8060 – Interceptive orthodontics – transitional dentition
- D8070 – Comprehensive orthodontics – transitional dentition
- D8080 – Comprehensive orthodontics – adolescent dentition
- D8090 – Comprehensive orthodontics – adult dentition
- D8210 – Removable appliance therapy – control harmful habits
- D8220 – Fixed appliance therapy – control harmful habits
- D8670 – Periodic orthodontic visit

6. Payment Assumptions:

- Half of total treatment plan would be paid after prior authorization obtained and provider bills the appropriate CDT code
- The remaining balance of the approved treatment plan would be paid in increments to be determined based on the treatment plan amount and length of treatment
- If the patient loses Medicaid eligibility during the course of the orthodontic treatment, the remaining unpaid balance of the orthodontic treatment plan will be paid in full to the treating dentist
    - The treating dentist will be expected to complete or make arrangements for the completion of the orthodontic treatment plan and submit copies of the final records to Medicaid
- No new orthodontic or surgical treatment will be authorized or paid after the patient loses Medicaid eligibility

7. Other Assumptions:

- If a surgical approach is treatment planned, all surgical treatment must be completed while the patient is Medicaid eligible, otherwise the patient and/or their family will be responsible for the surgical expenses
- No reimbursement will be provided for the work up of orthodontic cases that are not prior authorized
- No reimbursement will be provided for continuation of orthodontic cases for a patient who initiates orthodontic treatment through a private arrangement while the patient is Medicaid eligible, e.g. for cosmetic purposes or non-qualifying orthodontic cases
- Reimbursement will be provided for continuation of orthodontic cases for a patient who initiated orthodontic treatment through a private arrangement prior to becoming Medicaid eligible
    - This is directed at patients who due to a change in family circumstances become Medicaid eligible and would otherwise be unable to continue orthodontic treatment
    - This will not include patients who temporarily lose Medicaid eligibility due to non-timely re-enrollment and/or temporary changes in financial eligibility
- All submitted orthodontic prior authorizations will be reviewed by a board certified Texas orthodontist through the Health and Human Services Commission claims administrator contractor(s) responsible for dental claims review and payment to determine if the case qualifies for orthodontic treatment as outlined by orthodontic policy.

DRAFT

Orthodontic notes:

Cleft/craniofacial/syndromic and High level handicapping malocclusion patients requiring surgical intervention

Presenting Condition(s):

- Cleft palate
- Severe traumatic, skeletal and/or congenital deviations
- Severe facial asymmetry including skeletal and/or congenital origins
- Non-functional full Class II bite relationship
- Non-functional full Class III bite relationship

Requirements:

- Providers:
  - Limited to orthodontic board certified and orthodontic board eligible dentists who have completed a master's level curriculum at an accredited U.S. dental school
- Consultation with oral surgeon and preliminary surgical treatment plan documented on prior authorization form

Prior Authorization Submission Requirements:

- Completion of THSteps Orthodontic Treatment Plan Prior Authorization – Surgery form
  - Treatment plan must be signed by the submitting orthodontist, oral surgeon, and parent/guardian
- Radiographs
  - Panoramic
  - Cephalometric with tracings
  - Note: A 2-D or 3-D CT Scan can be substituted for the panoramic radiograph
- Photographic images (8-9)
  - Must include full face smiling, left and right profiles, full maxillary arch, full mandibular arch, right side occluded in centric relation, left side occluded in centric relation
  - Note: Photographic images must be taken in a 1:1 ratio format

Assumptions:

- Treatments plans will be reviewed for prior authorization by a board-certified orthodontist through the Health and Human Services Commission claims administrator contactor(s) responsible for dental claims review and payment to determine if the case qualifies for treatment as outlined in the Cleft/Craniofacial/Syndromic and High level handicapping malocclusion policy
- Reimbursement will be based on approved treatment plan
- Flexibility due to unique nature of the cleft/craniofacial/syndromic patients will be needed
- No new orthodontic or surgical treatment will be authorized or paid after the patient loses Medicaid eligibility

Drafted by: Linda M. Altenhoff, DDS
Based on orthodontic stakeholder input from 10.08.2008

Benefit Implementation Process (BIP)
Implementation Phase
September, 2008

Stage 3 Continued: Operational Implementation consists of numerous criteria for consideration. At this stage the policy is "operationalized." The Oversight SME is the lead. The BIP Project Manager (PM) coordinates the flow of the process and removes bottlenecks in the process.

Following items are determined:
- If over $50k acquire EC approval via action memo process, completed by OV PM
- TAC or Rule (SPA) changes
- Stakeholder vetting process if applicable
- edit/audit adjustments or creation
- system changes if applicable
- reference file changes

Focus on identifying parallel processes that can be initiated to save time. TMHP creates Business and User Requirements (BUR) document which details changes, as well as the technical plan for implementation. HHSC Oversight (OV) must sign/approve.

TMHP creates Functional Design document incorporating elements from the BUR. HHSC/OV SME must sign/approve.

TMHP Reference Files Team (RFT) sends pricing to Rate Analysis in preparation for rate hearing.

TMHP performs User Acceptance Testing (UAT) i.e. system changes are implemented in a test environment. Stakeholders are included. HHSC/OV SME must sign/approve.

TMHP Document Research Team (DRT) completes provider notification (bulletin article, banner message, web posting). Provider notification must be published 45 days prior to benefit implementation.

The benefit is implemented.

Benefit Implementation Process (BIP)
Medicaid Medical Policy Review and Development
September, 2008

Acronyms:
OMD- Office of Medical Director
OIG-Office of Inspector General
OV-Claims Admin. Oversight Office
TMHP- Texas Medicaid & Healthcare Partnership a coalition of vendors with ACS (Affiliated Computer Services) as the primary vendor.
BIL-Benefit Initiative Lead (AKA Clinical staff)
SME-Subject Matter Expert (AKA HHSC OV staff)
BUR-Business User Requirements
UAT- User Acceptance Testing

Topics for new or revised benefits may come from any number of sources including TMHP, HHSC (Executive Mgmnt, OMD, OIG, OV), Legislature, ICD-9/HCPCS, the provider community or other stakeholder.

Stage-1: **BIP/Benefit Management Workgroup (BMW)** is the clinical component of the Benefit Implementation Process. BMW reviews topics for new or revised benefits along with any corresponding changes to policy. The HHSC Medical Director chairs the workgroup.

Topics are referred to Physician Policy Review (PPR) Committee (as needed) for direction and advise regarding new policy or changes to existing policy.

TMHP creates Tracking Document.

TMHP Benefit Initiative Lead (BIL) conducts research and review in collaboration with the HHSC BIL until it reaches the BMW final draft. BMW meets bi-weekly BIL meetings conducted weekly. HHSC BIL's oversee TMHP BIL's work. They initiate and carry forward required research into the Texas Administrative Code (TAC), Code of Federal Regulations (CFR), State Plan (Medicaid), and Program rules in addition to clinical review.

TMHP BIL sends benefit information to HHSC Financial Services Strategic Decision Support (SDS) for client fiscal analysis review and approval. Fiscal also sent to Rates Analysis to determine need for rate hearing.

Fiscal impact is returned to BIP/BMW and the medical policy is prepared for final BMW approval and sign-off.

Stage 2: TMHP provides administrative tracking and performs housecleaning steps. i.e. confirmation memo and timeline. TMHP, HHSC Rate Analysis and OV BIP Project Manager (PM) conduct bi-weekly negotiations arriving at a proposed implementation date for newly approved policies with exception of policies requiring system changes. Note: Policies that require system changes are leveraged at TMHP/HHSC demand management meetings.

Stage-3:
BIP Operational Implementation
HHSC OV SME's take the lead and interface with TMHP Operations & other stakeholders. (See next page)