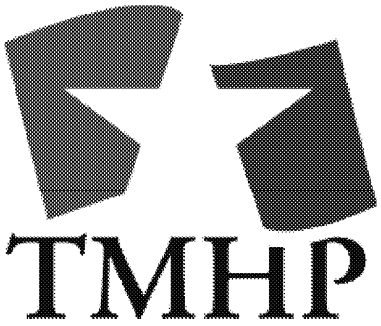


# Texas Health Steps (THSteps) Orthodontic Dental Services Benefit Policy Development

# Program 100/200

**Current Draft Version: Final Draft**

**Date of First BIL: July 18, 2007**

**Initial BMW: July 31, 2007**

**Placed on Hold: 09/19/2007**

**Return to BMW: February 10, 2009**

**Final Draft: June 30, 2009**

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**Topic or Policy:** Texas Health Steps (THSteps) Orthodontic Dental Services

**Program Type:** 100/200

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# 1. Policy Overview

Orthodontics is defined as moving teeth to correct their position in existing bone. Adolescent dentition is dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment. Comprehensive orthodontic treatment consists of repositioning all or nearly all of the permanent teeth in an effort to make the patient's occlusion as ideal as possible. This treatment usually requires complete fixed appliances.

## 1.1 Reason for Review

This policy is being brought through the BMW process for comprehensive review. The updated review in 2006 for CDT codes D8690 and D8080 and their relationship to orthodontic replacement brackets will be addressed in this review.

Access to care issues identified? ☒ Yes ☐ No
Issues with migrant and foster care clients getting their treatment completed are one area needs to be addressed.

Provider complaint issues identified? ☒ Yes ☐ No
Providers have the following questions, with TMHP response:

- 1. Who is involved in the review of orthodontic cases?
- TMHP dental specialists review the information the provider submits. If the client has an HLD score of 26 or greater (measuring the dysfunctional malocclusion), and the provider submits the x-rays with the request, the request is authorized. If an HLD score of less than 26 is documented the request is denied. Except when the dental provider puts a note on the request about the medical need for orthodontia even though they do not have an HLD score of 26, then the request is referred to the TMHP Dental Director for review.

- 2. What are the criteria for the review of orthodontic cases?
- If the client has a request submitted by a licensed general dentist, pediatric dentist or an orthodontist and the provider has submitted x-rays and the HLD scoring sheet with a result of 26 or greater, the specialists approve the request as per policy. If the x-rays are not submitted or the score is below 26 they deny the service. Except when there is narrative submitted along with the x-rays and the HLD score sheet with a result below 26, the request is reviewed by the TMHP Dental Director. The guidelines in the medical policy must be met for the specialists to approve the orthodontia.

- 3. What is the process when a difficult orthodontic case is presented?
- Any request that does not clearly meet guidelines but the provider submits information regarding why this should still be considered for approval (even though the guidelines are not met) are reviewed by the TMHP Dental Director.

- 4. What is the level of understanding of orthodontics by the providers who present orthodontic cases?
- According to the state law, any provider that is licensed by the State of Texas to practice dentistry can do orthodontics. This would include a general dentist, pediatric dentist, or an orthodontist.

- 5. What type of interceptive orthodontics is available for children in the age range of 6 to 7 years?
- Currently we authorize for treatment to correct an anterior or posterior crossbite.

Are the identified issues related to regulatory alignment? ☐ Yes ☒ No

Waste/fraud/abuse issues identified? ☐ Yes ☒ No

## 1.2 Stakeholder Direction

The policy review was first presented to the BMW on 07/18/2007. The policy was placed on hold 09/19/2007 to give the stakeholders an opportunity to voiced complaints/ concerns of the current policy.

The policy has returned to the BMW process 02/10/2009.

Dr. Linda Altenhoff presented information to the PPR on the Orthodontic Services policy. At this time, portions of the policy have been implemented. According to a banner/bulletin dated January 2005, changes to the authorization of these services are now in effect. Further review of this finds that while this information was released to providers, the current policy does not support the

publication. The pending version of the policy, which includes these changes, has not been officially implemented in the system and is not found on the EOPM. This was brought to Dr. Altenhoff's attention by OIG. The pending version of the policy has been reviewed on two separate occasions: once for changes to the authorization process and again at a later date for review of issues associated with the reimbursement of brackets.

The policy is returning for final review of the brackets issue. This issue has to do to with reimbursement of replacement brackets and transfer of orthodontic care.

Currently, providers bill this service using a non-specific code. Orthodontic care requires prior authorization, which results in the clients returning on a different date for the replacement of a bracket when the issue is identified in a follow-up visit.

Dr. Altenhoff recommendation is to modify procedure code D8080 (orthodontic care) such that it includes coverage for up to 10 replacement brackets. This will require an increase in the reimbursement for this service.

Concerns regarding the training needed to provide orthodontic care were raised by Dr. Altenhoff. There does not appear to be a systemic way to limit provider types, rendering of orthodontic treatment is dependent on a dentist's individual training and knowledge. Of concern is whether a limitation of orthodontic services only being provided by orthodontists would create access-to-care issues.

Dr. Altenhoff cited issues with client transfers.

PPR Guidance:

- Finalize recommendations for reimbursement of brackets.
- Implement the pending policy (which includes the authorization changes previously sent out in provider communication).
- Ultimate policy direction will depend on stakeholder input. A discussion with general dentists and orthodontists needs to occur regarding limitation of orthodontic services to orthodontists only.
- Perform a comprehensive review of the policy and address all other issues.

Additional Stakeholder Information Received from:

☒ HHSC ☐ CSHCN Services Program ☐ Family Planning (DSHS/ WHP)
☒ DSHS – Texas Health Steps (THSteps) ☒ DSHS – THSteps Dental
☒ OIG ☐ HMO ☐ Other

## 1.3 Impacts Identified During This Review

Refer to Final Recommendations and the Fiscal Impact section of this tracking document for discussion of any impacts identified below.

Changes to authorization: ☒ Yes ☐ No

RFT changes: ☒ Yes ☐ No

System Changes: ☒ Yes ☐ No

Adjudication Changes: ☒ Yes ☐ No

Rate Hearing: ☒ Yes ☐ No

End-dated/rolled into another policy: End date the current Texas Health Steps (THSteps) Orthodontic Dental Services policy and replace with the new policy.

Other: N/A

## 1.4 Standard Terms and Acronyms

*http://ausbida01/wdk/bid.jsp?09002f7780192a40*

# 2. Current Benefit Policy

This section contains links to the current information regarding the current policy.

## 2.1 Link(s) to eOPM for Current Benefit Policy Version(s) (if applicable)

*http://eopm.tmhp.net/eopm/Policy_manuals/Medi_Med_Pol/Output/Frameset.html*

## 2.2 Link to Current Policy Reference File Information

*Texas Health Steps (THSteps) Orthodontic Dental Services TD (Medicaid) (07312007).doc*

## 2.3 Relevant Utilization History (Includes Top 2 Relevant Denial EOBs)

*Texas Health Steps (THSteps) Orthodontic Dental Services TD (Medicaid) (07312007).doc*

# 3. Benefit Guidelines and Findings

The Benefit Guidelines and Findings section provides information regarding state guidelines and insurance coverage.

## 3.1 Current State Guidelines

**Code of Federal Regulations (CFR):** TITLE 42 -- PUBLIC HEALTH
Chapter Iv -- Centers For Medicare & Medicaid Services, Department Of Health And Human Services
Subchapter C -- Medical Assistance Programs
Part 441 -- Services: Requirements And Limits Applicable To Specific Services
Subpart B -- Early And Periodic Screening, Diagnosis, And Treatment (EPSDT) Of Individuals Under Age 21
42 CFR 441.56: Required activities.
(c) Diagnosis and treatment. In addition to any diagnostic and treatment services included in the plan, the agency must provide to eligible EPSDT recipients, the following services, the need for which is indicated by screening, even if the services are not included in the plan--
(1) Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids;
(2) Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and
(e) Timeliness. With the exception of the informing requirements specified in paragraph (a) of this section, the agency must set standards for the timely provision of EPSDT services which meet reasonable standards of medical and dental practice, as determined by the agency after consultation with recognized medical and dental organizations involved in child health care, and must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of 6 months after the request for screening services.

**State Plan (Medicaid):** N/A

**Texas Administrative Code (TAC):** Title 25, Part 1, Chapter 33, Subchapter A and G.
a) Orthodontic services are limited to treatment of severe handicapping malocclusion and other related conditions as described and measured by the procedures and standards published in the manual.
(b) Orthodontics for cosmetic reasons only is not a covered Medicaid service.

## 3.2 Current Coverage Findings

**Coverage Table:**

Table contains state coverage findings for Medicare, five (5) other Medicaid states and up to three (3) other insurance carriers, including "No Medicare information available". Response will be Y (yes), N (no) or U (unknown). State name and insurance carrier will be noted. Table 3.2- A

Medicare, Other Medicaid State and Other Insurance Carriers Coverage

| Procedure Code | Description | Medicare | New York | Iowa | Oregon | California | Louisiana | Connecticut |
|---|---|---|---|---|---|---|---|---|
| D8050 | Interceptive orthodontic treatment of the primary dentition | N | N | N | Y | Y | Y | N |
| D8060 | Interceptive orthodontic treatment of the transitional dentition | N | N | Y | Y | Y | Y | N |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition | N | Y | Y | Y | Y | Y | N |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition | N | Y | Y | Y | Y | Y | Y |
| D8090 | Comprehensive orthodontic treatment of the adult dentition | N | Y | N | Y | Y | Y | Y |
| D8210 | Comprehensive orthodontic treatment of the adult dentition | N | N | Y | Y | Y | Y | Y |
| D8660 | Comprehensive orthodontic treatment of the adult dentition | N | Y | N | Y | Y | Y | Y |
| D8670 | Periodic orthodontic treatment visit (as part of contract) | N | Y | N | Y | Y | Y | Y |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) | N | Y | Y | Y | Y | Y | Y |
| D8690 | Orthodontic treatment (alternative billing to a contract fee) | N | N | Y | Y | Y | Y | Y |
| D8692 | Replacement of lost or broken retainer | N | Y | Y | Y | Y | Y | Y |

**CCI: 02/04/2009:** Dental procedure codes are not listed in CCI.

## 3.3 Reference Materials Used

Medicare: (Date viewed 02/03/2009)
*http://www.cms.hhs.gov/LowCostHealthInsFamChild/SCHIPASPI/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=2&sortOrder=ascending&itemID=CMS1188499&intNumPerPage=10*

**New York Medicaid** (Date viewed 02/03/2009)
*http://www.health.state.ny.us/health_care/medicaid/fees/docs/dentalfees03.pdf*

**Iowa Medicaid** (Date viewed 02/03/2009)
*http://www.dhs.state.ia.us/PolicyAnalysis/PolicyManualPages/Manual_Documents/Provman/dental.pdf*

**Oregon Medicaid** (Date viewed 02/03/2009)
*http://www.dhs.state.or.us/policy/healthplan/guides/dental/123rb0109.pdf*

**California Medicaid** (Date viewed 02/03/2009)
*http://www.denti-cal.ca.gov/provsrvcs/manuals/sec5/Section_5.pdf*

**Louisiana Medicaid** (Date viewed 02/03/2009)
*http://www.lamedicaid.com/provweb1/manuals/Dental_Manual_FINAL_4_25_03l.pdf?bcsi_scan_C5EC56384FE2D763=b3biMuh87/F1pJ1KjFT75wUAAAA/ETcB&bcsi_scan_filename=Dental_Manual_FINAL_4_25_03l.pdf*

*Texas Health Steps.doc*

## 4. Evidence Based Research

Clinical review to include the standard of care and a brief synopsis of the current benefit. Add link to supporting documentation.

**Hayes – N/A**

**MD Consult – N/A**

**Other** – N/A

### 4.1 Reference Materials Used

Hayes: *https://www.hayesinc.com/subscribers/searchArticles.do*

# 5. Discussion

Included in this section are the summaries of discussions and research findings related to this policy review.

## 5.1 *Issue #1*- Prior Issues

**Identified Issue:** The comprehensive review has been on hold from 09/19/2007-02/05/2009.

**Related Issues:** Include other issues that may have been created as a result of this issue, or have cross implication.

**Initial Recommendation:** Issues from previous tracking document:

- The issue discussed is allowing the open-ended reimbursement of replacement brackets though the non-standard use of CDT code D8690 sets Medicaid up for potential misuse whether intentionally or unintentionally.
- Implement the pending policy (which includes the authorization changes previously sent out in provider communication).
- For the general dentist to treat the dentist would need 200 hours of continuing education and present 20 cases for peer review. After that the provider would be able to submit cases with the peer review doing spot checks.
- Review conflict of prior authorizations criteria of procedure codes D5951-D5960 as listed in the Therapeutic policy and the Orthodontic policy.
- Make procedure codes D8070 and W-D8090 benefits of Texas Medicaid program 100/200.
- Review PA processes as to if the criteria need to be strengthened.
- Statement added to the Transfer of Services section in the policy, "Authorization issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new authorization to complete the orthodontic treatment initiated by the original provider. The new authorization will only be for the completion of the original treatment plan".
- Local codes might need to be removed from provider manual and claims.
- The Handicapping Labio-Lingual Deviation (HLD) Index scoring sheet needs to be re-evaluated.
- Review the policy of paying for 2 out of every 10 cases submitted that are denied.
- Need to develop new policy with the changes identified during the stakeholder' meetings.

**Current Recommendation:** These prior issues have been resolved during the review of developing the new orthodontic policy.

**BIL Meeting/Feedback and discussion regarding recommendation: 07/13/2007**: The policy had started a review 10/10/2006, and was placed on hold. It is returning to the BMW process for a triennial review.
**07/18/2007 BIL Meeting Summary:** The PPR directive was presented.
**07/25/2007 BIL Meeting Summary**: Discussion held on the options for paying for brackets. Local codes discussed. PA Manager will send memo from HHSC regarding the issue of transferring services.
**08/01/2007 BIL Meeting Summary:** Final decision on payment of brackets was decided. Issue with using local codes in the remarks for D8080 was discussed. More research will need to be done before a decision will be made. Issue with procedure codes D5951-D5960 resolved. Research will need to be conducted on what other states are using to score clients instead of the HLD index. DR. Altenhoff will e-mail language to add to the policy to exclude clients that start treatment as private pay, and then request for Medicaid to pay the conclusion of treatment.

**08/09/2007 Orthodontic Workgroup**: The following items were points brought out for orthodontic policy.
There are items to be researched i.e., other HLD scoring and contact with TPR and their take on how other dental insurance would fit into place should the client have private dental insurance once eligibility is lost. Dr.
Altenhoff will be planning a stakeholder meeting before the next BIL meeting to get their input on the following points:

- Make the orthodontic approval process more stringent.
- Research the pre-payment process and TPR involvement.
- Decide the criteria as to what the incapacitated provider (retired/deceased) should be.
- Research if adding "CAD" for models, tracings, and radiographs is an option.
- Research the planning of orthodontic cases: Phase I -> Phase II (interceptive/transition orthodontics).
- Make the orthodontic program exclusive to Board Certified Orthodontists, PT90 (100/200), PT27 (400).

**09/19/2007 BIL Meeting:** Dr. Altenhoff, Manager, Oral Health Group Texas Department of State Health Services, request that research on concerns from stakeholders be done before scheduling meeting with stakeholders. The questions are:
The following issues are high with Frew and Orthodontic providers.
The following is to be researched and completed before Dr. Altenhoff can request a meeting and present to the Orthodontic Stakeholders.

- Who is involved in the review of orthodontic cases?

- What are the criteria for the review of orthodontic cases?

- What is the process when a difficult orthodontic case is presented?
- What is the level of understanding orthodontics by the providers who present orthodontic cases?
- What type of interceptive orthodontics is available for children in the age range of 6 to 7 years?

Dr. Altenhoff has requested these questions be researched for her to present to the orthodontic stakeholders. The meeting with the stakeholders will be scheduled when the research of 5 questions is complete. The review will be placed on hold until after stakeholder meeting.

**<02/05/2009> - BIL Meeting** The issues in the previous tracking documents located in the supporting documents of this review, issues will be looked at in the development of the new policy. The workgroup has decided that the current Texas Health Steps (THSteps) Orthodontic Dental Services will be end dated and a new policy will be developed.

## 5.2 *Issue #2*- Policy Language

**Identified Issue:** Develop new orthodontic policy with the stakeholders input.

**Related Issues:** N/A

**Initial Recommendation:** New Policy

**Current Recommendation:** New Policy developed for orthodontic services.

**BIL Meeting/Feedback and discussion regarding recommendation:**
**02/03/2009 Orthodontic workgroup:** The workgroup will be meeting two times a week to develop the revised orthodontic dental policy.
The following are the issues identified:

- The new orthodontic policy will consist of three levels, from level one being the simpler cases to level three being the cases requiring surgery.
- We will be reviewing the criteria for general dentist to do orthodontic services. This will require for provider enrollment's involvement as we create the new policy.
- There are issues with foster clients (Impact to Superior and sub contractor start-ends-) getting the orthodontic services needed.
- Will work with PCCM to determine if there is an impact.

- Will look at removing the local codes and billing with the most appropriate procedure codes.

| <02/04/2009> - BIL Meeting |
|---|
| An overview of the meeting from the day before reviewed for the BIL meeting. It was determined that we will work on the orthodontic and the cleft craniofacial and then will bring the orthognathic policy to update with any changes. The current orthodontic policy will be brought through to end date at that time. |
| **Action Items:**<br>Place the tracking document into the current updated form. Will place the current tracking into the supporting documents to reference. |

**02/10/2009 Workgroup meeting:** Continuation of policy development was discussed.
We will need to contact provider enrollment of the changes to the performing providers.
Providers will need to submit extra documentation to perform the orthodontic services. We want to have two levels of providers.

- For all levels - Dentists who are orthodontic board certified or orthodontic board eligible
- For level two and three - Dentists who are orthodontic board certified or orthodontic board eligible; or Completion of pediatric dental residency; or a minimum of 200 hours of continuing dental education in orthodontics.

Here are the issues we see might need system changes as we develop the policy.

- When providers submit a prior authorization on the portal site we want them to be able to attach the supporting documentation required for the authorization.
- We want to have new "sub specialty" for providers performing orthodontics. We want to be able to have a provider that has submitted extra documentation to perform these services. I know we did a similar change with the dental anesthesiologist last September.

| <02/11/2009> - BIL Meeting |
|---|
| Provider requirements discussed and decide how to place the information into the policy language.<br>Will need to place in the prior authorization section of clarifying which form to use and who will need to sign it.<br>It was decided that the policy history box should have more information than that the policy is a new policy. Spell out the differences from the end dated policy. |
| **Action Items:**<br>•Provider Requirement, section 7 of policy--- Create a cross table to note qualifications<br>*Response:* Table placed in the policy. Will explain who can provide which level of service. |

**02/12/2009**: E-mail sent to provider enrollment, "We are currently taking the orthodontic policy through the BMW process. HHSC has requested that we get provider enrollment involved early to help resolve an issue that has come up. They want to have general dentist submit extra documentation to perform orthodontics." Provider enrollment will be join the next workgroup meeting.
**02/12/2009:** E-mail sent to application services, "We are currently working on developing a new policy. The current policy is being end dated when we sign off the new policy through the BMW process. I have attached a draft of the new policy we are developing. It is in the very early stages, so it will not reflect the system changes we are anticipating.

Here are the issues I can see might need system changes as we develop the policy.

- When providers submit a prior authorization on the portal site we want them to be able to attach the supporting documentation required for the authorization.
- We want to have new "sub specialty" for providers performing orthodontics. We want to be able to have a provider that has submitted extra documentation to perform these services. I know we did a similar change with the dental anesthesiologist last September."

| **<02/18/2009> - BIL Meeting** |
|---|
| Dr. Forbes requested grammatical changes to the policy:<br>• Statement 2---- remove second sentence--- add "solely" before "for " in the first sentence<br>• Statement 9--- "service of severe" change to "service for severe"<br>• Statement 11.3.2--- change to "digit sucking" verses "thumb sucking"<br>• Statement 8--- update language<br>• Level 2, 12.1 and 12.2--- centric relation should read centric occlusion |

| **<02/24/2009> - BIL Meeting** |
|---|
| Dr. Altenhoff e-mail, "I have provided edits as discussed yesterday. I am also providing the requested justification language for the tracking document regarding interceptive orthodontics.<br><br>Interceptive orthodontics provides for improvement of arch form allowing for eruption of permanent teeth in a more normal alignment and occlusal relationship. This leads to improved function, may decrease the occurrence of gingivitis and dental caries, and improve health outcomes. Interceptive orthodontics may also prevent the need for the client to undergo more extensive orthodontic procedures, including orthognathic surgery, at a later date, also resulting in improved health outcomes and decreased Medicaid expenditures. |

**03/04/2009:** CSHCN has decided to follow Medicaid and place the policy on hold until Medicaid brings their back after developing the cleft and craniofacial policy.

**06/17/2009 BMW Meeting:** Policy presented for final draft. During the presentation of the cleft and craniofacial policy issues were discussed of the craniofacial teams. Final draft extended two weeks per HHSC request.

**06/25/2009:** Revisions received from Dr. Altenhoff.

## 5.3 *Issue #3*- Provider Types

**Identified Issue:** Review provider types.

**Related Issues:** N/A

**Initial Recommendation:** 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.

**Final Recommendation:** Provider enrollment will need to create a new certification for Portability that will be added to each of the providers that are eligible for a Portability Permit through the Board of Dental Examiners.

The requirements will be based on Provider Types: Dentists (D.D.S., D.M.D.) who want to provide any of the four levels of orthodontic services addressed in this policy must be enrolled in THSteps and must have the qualifications listed in Table A for the relevant level of service. Dentists must provide proof of qualifications to TMHP Provider Enrollment prior to the submittal of their first prior authorization request associated with this policy.

| Provider Requirements | Level of Orthodontic Service Qualifications |
|---|---|
| Level One or Two | Completion of pediatric dental residency; or A minimum of 200 hours of continuing dental education in orthodontics. |
| Level One, Two Three, or Four | Dentists who are orthodontic board certified or orthodontic board eligible. |

**BIL Meeting/Feedback and discussion regarding recommendation: 02/12/2009:** The following issues requested from HHSC will need to be review:

- 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.

- 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.

**02/13/2009**: E- mail from Special Project Director, "Requirement to have all orthodontics requests reviewed by a board certified orthodontist- This will have immense Operational impacts for PA/Medical Directors and require a COR with considerable expense to HHSC. Currently PA receives an average between 9,000 and 10,000 requests each month, of these 90-95% are orthodontics.
Currently less than 10% of requests are reviewed and that 100% review would require significant more Medical Director and PA staff which would need to be addressed in a COR due to the Operational impact.

2. Requirement that parent/guardian signs PA Orthodontics request form- This is contrary to all current PA practices and health care industry practices. Health care practices are that family/client signatures are required in the client/provider medical records, for example consents for surgeries, treatment plans, admission paperwork, releases of information, financial/billing forms, etc. The medical record is where documentation that a client/family understands and agrees to the proposed treatment resides. Adding these signatures to the PA request form, will cause undo hassle for providers, create another reason for requests to be pended or returned to providers, causing significant delays in treatment, and remember dental requests are mailed. These signatures have never been on PA requests, as they have nothing to do with establishing medical necessity. THMP should not become a document depository for information that belongs in provider medical records."

| **<02/18/2009> - BIL Meeting** |
|---|
| Special Project Director requested to discuss the overwhelming impacts that will happen if only board certified orthodontists are the only reviewers for orthodontic prior authorizations. At this time the PA department receives roughly 9,000 -10,000 request a month for dental services which approximately 90 -95% are for orthodontics. This would require a significant amount of extra staff and cost; that would require a COR which is not part of the medical policy development. TMHP BIL recommends that we table this issue until the next workgroup scheduled for Tuesday.<br><br>The second issue that the Special Project Director requested to discuss is requesting the parent or guardian to sign the orthodontic treatment plan. The issue is that he does not believe the parent or guardian's signature should be required before an authorization is reviewed. This also needs to be tabled for discussion until our next workgroup meeting. |

**06/11/2009:** Need to create a new subspecialty for the orthodontic services. TMHP Provider Enrollment
Will need to answer the following questions:
1) Will a new traditional application need to be submitted? *Response:* If the Provider is not currently in our system a new application will need to be submitted. We may possibly need to come up with an additional form that could show the subspecialty code. If they are currently in our system and have a TPI, we may be able to have them just submit the form.

2) Will a separate suffix be required? *Response:* Yes, we will need a separate suffix to show the physical location they are rendering services.

3) Can a Group be part of the team or should there only be an individual designation? It all depends on if the Group's designation will not change of one party leaves. In the case, if a member leaves, do we want the whole group to be ended as well? *Response:* Also, I believe we are working on a similar situation at this time because we will need to be able to track the Group, but if there is no way for us to track its members, this would possibly be a problem regarding audit purposes.

## 5.4 *Issue #4*- Reference File Changes

**Identified Issue:** Review RFT to ensure new policy language is enforced in the system.

**Related Issues: N/A**

**Initial Recommendation:** Make procedure codes W-D8010, W-D8020, W-D8070, W-D8090, W-D8691, and W-D8692 a new benefit of program 100/200:

- PT: 46, 48, 90, 91, 92
- POS: 1
- Age: 0-20
- Edits: 00046

End date procedure codes W-D8670, W-D8660, W-D8690, and W-D8999 as a benefit for program 100/200 for all provider types and place of service.

End date procedure codes W-D8050, W-D8060, W-D8080, W-D8220, and W-D8680 from audit 02105.

**Final Recommendation:** Make procedure codes W-D8010, W-D8020, W-D8070, and W-D8090 a new benefit of program 100/200:

Procedure code PT/POS, age, and sex should be set up as follows:

- PT: 46, 48, 90, 91, 92
- POS: 1
- Age: 0-20 yrs Sex: B
- Edits: Add authorization criteria to the auth tab of the procedure codes so that they set edit 00046
- Add BM 2R8 for PT 46 to pay the encounter
- Add these codes to procedure grouping FQH1

Make procedure codes W-D8691, and W-D8692 a new benefit of program 100/200:
Procedure code PT/POS, age, and sex should be set up as follows:

- PT: 46, 48, 90, 91, 92
- POS: 1, 3, & 5
- Age: 6-999 yrs Sex: B
- Add BM 2R8 for PT 46 to pay the encounter
- Add these codes to procedure grouping FQH1

Make procedure codes W-D8670, W-D8660, W-D8690, and W-D8999 not a benefit for CT 021 with non-covered EOB 00550.

End date procedure codes W-D8050, W-D8060, W-D8080, W-D8220, and W-D8680 from audit 02105. (If the CSHCN like policy does not have this same recommendation or does not implement at the same time the codes can still be removed from audit 02105 but a new audit that mirrors 02105 specific to CSHCN will need to be built for these codes.)

End date PT 03 from procedure codes W-D8210, W-D8220, W-D8050, W-D8060, W-D8080, W-D8680, and W-D8693.

Add subject procedure code W- W-D8680 to audit 02550 (PROCEDURE INCLUDED IN ANOTHER PROCEDURE, SAME DAY, ANY PROVIDER (MEDICAID)) to deny when billed on the same day, any provider as W-D8010, W-D8020, W-D8210, W-D8220, W-D8050, W-D8060, WD8070, W-D8080, and W-D8090.

Add subject procedure code W-D0330 to audit 00703 (Initial orthodontia visit within lifetime other orthodontic procedures, same provider (Dental)) to deny when billed on the same day, any provider as W-D8010, W-D8020, W-D8210, W-D8220, WD8070, and W-D8090.

New rate proposal for the following procedure codes:

- Procedure codes W-D8010, W-D8020, W-D8210, W-D8220: $937.50
- Procedure codes W-D8050 and W-D8060: $1,737.50
- Procedure codes W-D8070 and W-D8080: $2,500.00
- Procedure code W-D8090: $3,100.00
- Procedure code W-D8691 and W-D8692 : TBD

**BIL Meeting/Feedback and discussion regarding recommendation:**

| |
|---|
| **<02/04/2009> - BIL Meeting** Reference files will be reviewed after the policy language has been developed. |

| **<02/18/2009> - BIL Meeting** |
|---|
| OV recommends that we remove PT 03 (County Indigent Health Care Program) for the dental procedure codes. It was discussed that the Indigent could do the general dentist, but not the orthodontics.<br>Reviewed which procedure codes will be for which level of service. Will need to determine if D8080 will need to be set up with a modifier for level three. |
| **Action Items:**<br>**OV**<br>The SME will research if we need to remove PT 03 from the orthodontics procedure codes.<br>E-mail from OV, "I just spoke with Jan Maberry regarding CIHCP and dental. The program only bills medical, even for dental they bill only medical, which means they bill only on the CMS-1500. In this case we would be able to remove the PT03 from all THSteps Dental benefits, i.e., therapeutic, preventive, orthodontic etc." Remove PT 03 from procedure codes in the policy. |

| **<02/24/2009> - BIL Meeting** |
|---|
| It was determined that add POS 03 and 05 to all procedure codes in the policy. Policy placed on hold to develop the cleft and craniofacial policy. |

| **<05/20/2009> - BIL Meeting** |
|---|
| Policy returned to the BMW process. Procedure codes were discussed as to what procedure codes would be for each level of service. We will add a level four to the policy. The following procedure codes for each level as follows:<br>• Level one: D8020, D8210, D8220<br>• Level Two: D8050, D8060<br>• Level Three: D8070, D8080<br>• Level Four: D8090<br>The procedure codes will be set up as a comprehensive payment. It was determined by the |

workgroup that the payment will be divided by two payments; half will be paid at the beginning with banding and the other half at the time of completion or if the client loses eligibility. The following procedure codes will be end dated as part of part of the comprehensive service:

- W-D8660
- W-D8670
- W-D8690

Will need to work with RFT to remove all crosswalks from the procedure codes.

**06/02/2009**: RFT recommendations after policy language finalized:

Make procedure codes W-D8010, W-D8020, W-D8070, W-D8090, W-D8691, and W-D8693 a new benefit of program 100/200:

- PT: 3, 46, 48, 90, 91, 92
- POS: 1
- Age: 0-20
- Edits: 00046

End date procedure codes W-D8670, W-D8660, W-D8690, and W-D8999 as a benefit for program 100/200 for all provider types and place of service.

End date procedure codes W-D8050, W-D8060, W-D8080, W-D8220, and W-D8680 from audit 02105.

## 5.5 *Issue #5*- Prior Authorization Forms

**Identified Issue: 05/11/2009:** Create new prior authorization forms.

**Related Issues:** Refer to the Texas Health Steps (THSteps) Cleft and Craniofacial Services Policy.

**Initial Recommendation:** Create forms: Texas Health Steps (THSteps) Non -Surgical Orthodontic Prior Authorization form and Texas Health Steps (THSteps) Surgical Orthodontic Prior Authorization form.

**Final Recommendation:** Providers will need to use the new forms:
Texas Health Steps (THSteps) Non -Surgical Orthodontic Prior Authorization form
Texas Health Steps (THSteps) Surgical Orthodontic Prior Authorization form.

Revise current THSteps Dental Mandatory Prior Authorization Request Form to remove the orthodontic request section.

**BIL Meeting/Feedback and discussion regarding recommendation: 05/11/2009:** New forms created for prior authorization.

| **<05/20/2009> - BIL Meeting** |
| --- |
| Modifications made to the forms.<br>HHCS BIL will work on language for the physician certification and the parent acknowledgement statement. |

**06/25/2009**: Revisions made to the authorization form as submitted by Dr. Altenhoff.

# 6. Final Recommendations

The final recommendations for the recommendations issues in section 5 are covered in this section.

**Rate Hearing Needed?** ☒ Yes ☐ No **Fiscal Issue # 1**

## 6.1 Issue # 1 Prior Issues Recommendation

**Fiscal Impact?** ☐ Yes ☒ No

These prior issues have been resolved during the review of developing the new orthodontic policy.

## 6.2 Issue # 2 Policy Language Recommendation

**Fiscal Impact?** ☐ Yes ☒ No

New Policy developed for orthodontic services.

## 6.3 Issue # 3 Provider Type Recommendation

**Fiscal Impact?** ☐ Yes ☒ No

Provider enrollment will need to create a new certification for Portability that will be added to each of the providers that are eligible for a Portability Permit through the Board of Dental Examiners.

## 6.4 Issue # 4 Reference Files Recommendation

**Fiscal Impact?** ☒ Yes ☐ No Fiscal Issue(s) # 1

Make procedure codes W-D8010, W-D8020, W-D8070, and W-D8090 a new benefit of program 100/200:

Procedure code PT/POS, age, and sex should be set up as follows:

- PT: 46, 48, 90, 91, 92
- POS: 1
- Age: 0-20 yrs Sex: B
- Edits: Add authorization criteria to the auth tab of the procedure codes so that they set edit 00046
- Add BM 2R8 for PT 46 to pay the encounter
- Add these codes to procedure grouping FQH1

Make procedure codes W-D8691, and W-D8692 a new benefit of program 100/200:
Procedure code PT/POS, age, and sex should be set up as follows:

- PT: 46, 48, 90, 91, 92
- POS: 1, 3, & 5
- Age: 6-999 yrs Sex: B
- Add BM 2R8 for PT 46 to pay the encounter
- Add these codes to procedure grouping FQH1

Make procedure codes W-D8670, W-D8660, W-D8690, and W-D8999 not a benefit for CT 021 with non-covered EOB 00550.

End date procedure codes W-D8050, W-D8060, W-D8080, W-D8220, and W-D8680 from audit 02105. (If the CSHCN like policy does not have this same recommendation or does not implement at the same time the codes can still be removed from audit 02105 but a new audit that mirrors 02105 specific to CSHCN will need to be built for these codes.)

End date PT 03 from procedure codes W-D8210, W-D8220, W-D8050, W-D8060, W-D8080, W-D8680, and W-D8693.

Add subject procedure code W- W-D8680 to audit 02550 (PROCEDURE INCLUDED IN ANOTHER PROCEDURE, SAME DAY, ANY PROVIDER (MEDICAID)) to deny when billed on the same day, any provider as W-D8010, W-D8020, W-D8210, W-D8220, W-D8050, W-D8060, WD8070, W-D8080, and W-D8090.

Add subject procedure code W-D0330 to audit 00703 (Initial orthodontia visit within lifetime other orthodontic procedures, same provider (Dental)) to deny when billed within a lifetime, same provider W-D8010, W-D8020, W-D8210, W-D8220, WD8070, and W-D8090,

New rate proposal for the following procedure codes:

- Procedure codes W-D8010, W-D8020, W-D8210, W-D8220: $937.50
- Procedure codes W-D8050 and W-D8060: $1,737.50
- Procedure codes W-D8070 and W-D8080: $2,500.00
- Procedure code W-D8090: $3,100.00
- Procedure code W-D8691 and W-D8692 : TBD

## 6.5 Issue # 5 Prior Authorization Forms

Create forms: Texas Health Steps (THSteps) Non -Surgical Orthodontic Prior Authorization form and Texas Health Steps (THSteps) Surgical Orthodontic Prior Authorization form.

Revise current THSteps Dental Mandatory Prior Authorization Request Form to remove the orthodontic request section.

*Return to the Discussion section.*

## 6.6 Claims Adjudication Updates

N/A

## 6.7 RFT Recommendations

Make procedure codes W-D8010, W-D8020, W-D8070, and W-D8090 a new benefit of program 100/200:
Procedure code PT/POS, age, and sex should be set up as follows:

- PT: 46, 48, 90, 91, 92
- POS: 1
- Age: 0-20 yrs Sex: B
- Edits: Add authorization criteria to the auth tab of the procedure codes so that they set edit 00046
- Add BM 2R8 for PT 46 to pay the encounter
- Add these codes to procedure grouping FQH1

Make procedure codes W-D8691, and W-D8692 a new benefit of program 100/200:
Procedure code PT/POS, age, and sex should be set up as follows:

- PT: 46, 48, 90, 91, 92
- POS: 1, 3, & 5
- Age: 6-999 yrs Sex: B
- Add BM 2R8 for PT 46 to pay the encounter
- Add these codes to procedure grouping FQH1

Make procedure codes W-D8670, W-D8660, W-D8690, and W-D8999 not a benefit for CT 021 with non-covered EOB 00550.

End date procedure codes W-D8050, W-D8060, W-D8080, W-D8220, and W-D8680 from audit 02105. (If the CSHCN like policy does not have this same recommendation or does not

implement at the same time the codes can still be removed from audit 02105 but a new audit that mirrors 02105 specific to CSHCN will need to be built for these codes.)

End date PT 03 from procedure codes W-D8210, W-D8220, W-D8050, W-D8060, W-D8080, W-D8680, and W-D8693.

Add subject procedure code W-D8680 to audit 02550 (PROCEDURE INCLUDED IN ANOTHER PROCEDURE, SAME DAY, ANY PROVIDER (MEDICAID)) to deny when billed on the same day, any provider as W-D8010, W-D8020, W-D8210, W-D8220, W-D8050, W-D8060, WD8070, W-D8080, and W-D8090.

Add subject procedure code W-D0330 to audit 00703 (Initial orthodontia visit within lifetime other orthodontic procedures, same provider (Dental to deny when billed within a lifetime, same provider W-D8010, W-D8020, W-D8210, W-D8220, WD8070, and W-D8090.

New rate proposal for the following procedure codes:

- Procedure codes W-D8010, W-D8020, W-D8210, W-D8220: $937.50
- Procedure codes W-D8050 and W-D8060: $1,737.50
- Procedure codes W-D8070 and W-D8080: $2,500.00
- Procedure code W-D8090: $3,100.00
- Procedure code W-D8691 and W-D8692 : TBD

## 6.8 System Recommendations

Provider enrollment will need to create a new certification for Portability that will be added to each of the providers that are eligible for a Portability Permit through the Board of Dental Examiners.

Dentists (D.D.S., D.M.D.) who want to provide any of the four levels of orthodontic services addressed in this policy must be enrolled in THSteps and must have the qualifications listed in Table A for the relevant level of service. Dentists must provide proof of qualifications to TMHP Provider Enrollment prior to the submittal of their first prior authorization request associated with this policy.

| Provider Requirements | Level of Orthodontic Service Qualifications |
|---|---|
| Level One or Two | Completion of pediatric dental residency; or A minimum of 200 hours of continuing dental education in orthodontics. |

| | |
|---|---|
| Level One, Two Three, or Four | Dentists who are orthodontic board certified or orthodontic board eligible. |

New forms created for Orthodontic Services. These forms need to be placed on the portal. The forms are located in the Texas Health Steps (THSteps) Orthodontic Dental Services tracking document.

- Texas Health Steps (THSteps) Non -Surgical Orthodontic Prior Authorization form
- Texas Health Steps (THSteps) Surgical Orthodontic Prior Authorization form

Revise current THSteps Dental Mandatory Prior Authorization Request Form to remove the orthodontic request section.

## 6.9 Rate Change Recommendations

The procedure codes will be set up as a comprehensive payment. It was determined by the workgroup that the payment will be divided by two payments; half will be paid at the beginning with banding and the other half at the time of completion or if the client loses eligibility.

New rate proposal for the following procedure codes:

- Procedure codes W-D8010, W-D8020, W-D8210, W-D8220: $937.50
- Procedure codes W-D8050 and W-D8060: $1,737.50
- Procedure codes W-D8070 and W-D8080: $2,500.00
- Procedure code W-D8090: $3,100.00
- Procedure code W-D8691 and W-D8692 : TBD

# 7. Estimated Client Services Fiscal Impact

| |
|---|
| In general, the use of HMO encounter data may result in an overestimation or underestimation of actual utilization due to differences in how HMO claims are adjudicated and the level of detail available in the Business Objects Encounters Warehouse. |

*For new benefits where denied claims were used to estimate FFS/PCCM utilization, the HMO data may be an underestimation of claims since denied claims are not part of the HMO data set and HMOs are not required to use the same Explanation of Benefits as are used by TMHP. Since HMOs may pay for services not covered by FFS/PCCM, Business Objects queries for new benefits were run for both paid HMO and denied FFS/PCCM claims by procedure code.*

*For any change in TOS to/from 4/5/6/I/T, 2/8/F, or 9/J/L the HMO data may be an overestimation of claims since TOS specificity is not currently available for HMO data.*

*For all rate changes involving TOS 4/5/6/I/T, 2/8/F, or 9/J/L the HMO data may be an overestimation of claims since TOS specificity is not currently available for HMO data.*

## 7.1 Executive Overview of Fiscal Issues

1. Make procedure codes W-D8010, W-D8020, W-D8070, and W-D8090 a new benefit of program 100/200.
2. Make procedure codes W-D8691, and W-D8692 a new benefit of program 100/200.
3. Make procedure codes W-D8670, W-D8660, W-D8690, and W-D8999 not a benefit for CT 021 with non-covered EOB 00550.
4. End date procedure codes W-D8050, W-D8060, W-D8080, W-D8220, and W-D8680 from audit 02105.
5. End date procedure codes W-D8010, W-D8020, W-D8210, W-D8220, W-D8050, W-D8060, W-D8070, W-D8080, W-D8090, W-D8680, W-D8691, W-D8692, and W-D8693 from PT 3.
6. Add procedure code W-D8680 to audit 02550 (Add subject procedure code W-D8680 to audit 02550 (PROCEDURE INCLUDED IN ANOTHER PROCEDURE, SAME DAY, ANY PROVIDER (MEDICAID)) to deny when billed on the same day, any provider as W-D8010, W-D8020, W-D8210, W-D8220, W-D8050, W-D8060, WD8070, W-D8080, and W-D8090.

## 7.2 Fiscal Impact Related to Current Benefit Changes

**Fiscal Issue #1:** Deny procedure codes XXXXXX, XXXXXX, and XXXXXX when billed on the same date of service by same provider as procedure code XXXXXX.

On a Business Objects query run on 00/00/0000 for SFY XXXX, a total of $XXXX was reimbursed for the procedure codes listed above when billed with procedure code XXXXXX on the same date of service by the same provider.

The estimated client services fiscal impact associated with this benefit current change is $XXXX

**Fiscal Issue #2:** Deny procedure code XXXXXX when billed on the same date of service by the same provider as procedure codes XXXXXX, XXXXXXX, and XXXXXX.

On a Business Objects query run on 00/00/0000 for SFY XXXX, a total of $XXXX was reimbursed for procedure code XXXXXX when billed with procedure codes XXXXXX, XXXXXX, and XXXXXXX on the same date of service by same provider.

The estimated client services fiscal impact associated with this current benefit change is $XXXX.

Table 7.2-A

| Current Benefit Changes | | | | | | |
|---|---|---|---|---|---|---|
| *TOS* | *Procedure Codes* | *POS* | *PT* | *Paid Claims* | *Qty Denied* | *HMO* |
| | | | | | | |
| | | | | | | |

The total estimated client services fiscal associated with these current benefit changes is: $XXXX

## 7.3 Fiscal Impact Related to New Benefit Changes

For new benefits where denied claims were used to estimate FFS/PCCM utilization, the HMO data may be an underestimation of claims since denied claims are not part of the HMO data set and HMOs are not required to use the same Explanation of Benefits as are used by TMHP. Since HMOs may pay for services not covered by FFS/PCCM, Business Objects queries for new benefits were run for both paid HMO and denied FFS/PCCM claims by procedure code.

For all rate changes involving TOS 4/5/6/I/T, 9/J/L or 2/8/F, the HMO data may be an overestimation of claims since TOS specificity is not currently available for HMO data.

**Fiscal Issue #1:** Make the following procedure codes a benefit of Texas Medicaid for program 100/200 for the provider types and places of service listed below.

Table 7.3-A

| New Benefit Changes | | |
|---|---|---|
| *Procedure Code* | *PT* | *POS* |
| | | |
| | | |

**Assumptions:** Based on the information gathered from the TMHP Associate Medical Director regarding the number of requests received per year and data gathered from the utilization history, as well as the listed research, it is estimated that <enter estimations here>.

Table 7.3-B

| | | | |
|---|---|---|---|
| *Procedure Code* | *Estimated New Claims* | *Fee* | *Estimated Impact* |
| | | | |
| | | | |
| | | | |

The total estimated client service fiscal impact associated with this new benefit is $XXXX.

## 7.4 Total Estimated Client Services Fiscal Impact for Current and New Changes

The total estimated client services fiscal impact associated with these changes are: $XXXX

## 7.5 Reference Materials Used for Fiscal Assumptions

Name of article or website ***http://www.aetna.com/cph/data/CPBA0250.html*** (viewed XXX/XX/XXXX).

# 8. Publications

This section of the tracking document includes the banner, bulletin, and web page notification for release to the providers. Also, in this section are any provider manual changes that impact this policy.

## 8.1 Banner Message Verbiage

(xx/xx/xx through xx/xx/xx) *****Attention All Dental Providers*****

Effective for dates of service on or after (Month, day, year), Texas Health Steps (THSteps) orthodontic dental services will change for Texas Medicaid.

Details of these changes are available on the TMHP website at www.tmhp.com and will be published in the (Month/Month) 200X *Texas Medicaid Bulletin*, No. XXX.

For more information, call the TMHP Contact Center at 1-800-925-9126.

## Bulletin/Web Page Article Verbiage:

**Article Title:** THSteps Orthodontic Dental Services Changes

**Descriptive Overview:**

Effective for dates of service on or after (Month, day, year), Texas Health Steps (THSteps) orthodontic dental services will change for Texas Medicaid. Click on the title to view the details.

**Article:**

**Article:**

Procedure codes D8010, D8020, D8070, D8090, D8691, and D8692 are new benefits of Texas Medicaid. These procedure codes may be reimbursed to orthodontist, oral maxillofacial surgeons, rural health clinics, federally qualified health centers (FQHC), THSteps-dental and group providers in the office for clients birth through 20 years of age.

Procedure codes D8660, D8670, D8690, and D8999 will no longer be benefits of Texas Medicaid.

Procedure codes D8050, D8060, D8080, and D8680 will no longer be limited to once per lifetime.

THSteps orthodontic dental services will be covered under four different orthodontic services levels, which are described below.

**Provider Requirements**

Providers must follow all provider requirements in order to be reimbursed orthodontic dental services.

All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including the standards for documentation and record maintenance that are stated in the TSBDE Rules 108.7 Minimum Standards of Care, General and 108.8 Records of the Dentist.

Dentists (D.D.S., D.M.D.) who want to provide any of the four levels of orthodontic services must be enrolled in THSteps and must have the following qualifications for the relevant level of service.

**Level One or Two**

- Completion of pediatric dental residency; or
- A minimum of 200 hours of continuing dental education in orthodontics; or
- Dentists who are orthodontic board certified or orthodontic board eligible.

**Level Three or Four**

- Dentists who are orthodontic board certified or orthodontic board eligible

Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid.

**Level of Orthodontic Service**

There are four different orthodontic service levels for severe handicapping malocclusion and each requires a different amount of time for treatment. These levels require different levels of skill, orthodontic procedures, and time for completion of the treatment plan. The levels are addressed from the least involved (level one) to the most involved (level four).

Criteria for levels two, three, and four include different types of malocclusion identified using Angle's classification, which is based on where the buccal groove of the mandibular first molar contacts the mesiobuccal cusp of the maxillary first molar.

The American Association of Oral and Maxillofacial Surgeons classification of occlusion or malocclusion is as follows:

- Class I: A Class I occlusion exists with the teeth in a normal relationship when the mesialbuccal cusp of the maxillary first permanent molar coincides with the buccal groove of the mandibular first molar.
- Class II: A Class II malocclusion occurs when the mandibular teeth are distal or behind the normal relationship with the maxillary teeth. This can be due to a

deficiency of the lower jaw or an excess of the upper jaw, and therefore, presents two types: (1) Division I is when the mandibular arch is behind the upper jaw with a consequential protrusion of the upper front teeth. (2) Division II exists when the mandibular teeth are behind the upper teeth, with a retrusion of the maxillary front teeth. Both of these malocclusions have a tendency toward a deep bite because of the uncontrolled migration of the lower front teeth upwards.

- Class III: A Class III malocclusion occurs when the lower dental arch is in front of (mesial to) the upper dental arch. People with this type of occlusion usually have a strong or protrusive chin, which can be due to either horizontal mandibular excess or horizontal maxillary deficiency. Commonly referred to as an under bite.

**Level One**

Level one involves minor treatment to control harmful habits, and/or limited or interceptive orthodontics of the transitional dentition. These procedures lessen the severity or future effects of a malformation, eliminate its cause, or may include localized tooth movement. This level requires a lower level of skill, orthodontic procedures, and time to complete treatment.

The following are interceptive orthodontics of the transitional dentition:

- Palatal or mandibular expansion.
- Crossbite correction.
- Treatment to control harmful habits: tongue thrust or digit sucking

**Level Two**

Level two includes a low-level severe handicapping malocclusion that may or may not require a surgical approach.

**Level Three**

Level three is a mid-level severe handicapping malocclusion that will require a surgical approach.

**Level Four**

Level four is a high-level severe handicapping malocclusion that will require a surgical approach.

**Authorization Requirements**

Prior authorization is required for all orthodontic services except for the repair of orthodontic appliances and replacement of lost or broken retainers. Documentation must support medical necessity of any appliance requested.

The TMHP Dental Director or designee must review all requests.

Only one orthodontic treatment dentition procedure code will be prior authorized at a time.

The Texas Health Steps (THSteps) Non -Surgical Orthodontic Prior Authorization form or Texas Health Steps (THSteps) Surgical Orthodontic Prior Authorization form must be signed and dated by the performing dental provider. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures/dates will not be accepted. The authorization form must include the procedure codes for services requested. The dental provider must maintain a copy of the completed, signed, and dated authorization form in the client's medical record. The prescribing dental provider must maintain the authorization form with the original dated and signature in the client's medical record.

Prior authorization request may be requested through the TMHP website at www.tmhp.com or mailed to the following:

Texas Medicaid & Healthcare Partnership
THSteps and ICF-MR Dental
Authorization
PO Box 202917
Austin, TX 78720-2917

The dental provider is responsible for explaining all treatment options to the parent and or guardian for all appropriate orthodontic treatments. The dental provider must discuss and document the family's ability and willingness to follow the recommended treatment instructions. The discussion with the family must include, but is not limited to the following:

- Verbalizing and understanding the orthodontic treatment options.
- Agreeing to follow the dental provider's treatment plane.
- Agreeing to the treatment plan by signing the consent form.

In situations where the orthodontic appliance and associated services has been abused or neglected by the client, the client's family, or the caregiver a referral to the Department of State Healthcare Services (DSHS) THSteps Case Management unit will be made by the Dental Services unit for clients 20 years of age or younger. The provider will be notified that the State will be monitoring this client's services to evaluate the safety of the environment for both the client and equipment.

The level of orthodontic services requested determines which form the provider is required to use.

- Level one: Texas Health Steps (THSteps) Non -Surgical Orthodontic Prior Authorization form.
- Level two: Either the Texas Health Steps (THSteps) Non -Surgical Orthodontic Prior Authorization form or Texas Health Steps (THSteps) Surgical Orthodontic Prior Authorization form.
- Level three or four: Texas Health Steps (THSteps) Surgical Orthodontic Prior Authorization form.

The orthodontic treatment plan must include all of the procedures that are required to complete the requested treatment including but not limited to the following:

- Medically necessary extractions
- Orthognathic surgery
- Upper and lower appliance
- Monthly adjustments
- Appliance removal (if indicated)
- Special orthodontic appliances

The treatment plan should incorporate only the minimum number of appliances that are required to properly treat the client. Requests for multiple appliances to treat an individual arch will be reviewed for the duplication of purpose.

Radiographs submitted must include, but are not limited to, the following:

- Panoramic: A 2-D or 3-D CT scan can be substituted for the panoramic radiograph
- Cephalometric with tracings

Photographic images must be submitted with the request and must be in a 1:1 ratio format (actual size), including, but is not limited to, the following:

- Full face smiling
- Left and right profiles
- Full maxillary arch
- Full mandibular arch
- Right side occluded in centric occlusion
- Left side occluded in centric occlusion

- Anterior occluded in centric occlusion

**Level One**

Providers that submit a request for crossbite therapy must maintain documentation in the client's dental record, which supports that the following criteria have been met:

- Posterior teeth - Are not end-to-end, but the buccal cusp of the upper teeth is lingual to the buccal cusp of the lower teeth.
- Anterior teeth - The incisal edge of the upper teeth are lingual to the incisal edge of the opposing arch.
- Crossbite therapy (limited orthodontics) is allowed for primary, mixed, or permanent dentition.

Crossbite therapy will not be considered for mixed dentition when there is a need for full banding of the adult teeth.

**Level Two**

To be considered as having a low-level severe handicapping malocclusion and to qualify for level two orthodontic treatment, the client must have supporting documentation indicating that a minimum of four conditions are present:

- Partial Class II: The mesiobuccal cusp of the maxillary first molar is 2 mm mesial from its Class I relationship with the mandibular first molar in centric occlusion
- Partial Class III: The mesiobuccal cusp of the maxillary first molar is 2 mm distal from its Class I relationship with the mandibular first molar in centric occlusion
- 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: Must measure 4 mm to 5.9 mm
- Overjet: Must measure 4.5 mm to 6.9 mm
- Crowding of mandibular anterior teeth: Must measure 4.5 mm or greater
- Maxillary peg laterals
- Congenitally missing teeth
- Midline discrepancy: Must measure 2 mm or greater
- Division 2 maxillary anterior relationship

- Maxillary diastema: Must measure 2mm or greater
- Generalized spacing in the upper arch: Must measure 5 mm or greater
- Generalized spacing in the lower arch: Must measure 5 mm or greater
- No overbite: End-to-end anterior relationship

NOTE: Each condition listed above is counted as one discrepancy and not two or three of the same discrepancy. Functional discrepancies must be documented to support consideration of orthodontic treatment for severe handicapping malocclusion.

**Level Three**

When surgical intervention is considered, a consultation with an oral surgeon is required and the prior authorization form must include documentation of the preliminary surgical treatment developed by the oral surgeon during consultation and must include any necessary extractions or exposure of impacted teeth (not including third molars)

To be considered as having a mid-level severe handicapping malocclusion and to qualify for level three orthodontic treatment, the client must have one of the following conditions present:

- Semi-functional full Class II bite relationship
- Semi-functional full Class III bite relationship
- Cuspid crowding: If a cuspid is blocked out and measures 4 mm or less space 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, and anterior or posterior
- Impacted teeth that exclude third molars
- Overbite: Must measure 6 mm or greater
- Overjet: Must measure 7 mm or greater

**Level Four**

A consultation with an oral surgeon is required and the prior authorization form must include documentation of the preliminary surgical treatment developed by the oral surgeon during consultation and must include the need for orthognathic surgery, the

surgical approach that will be used, and include any necessary extractions or exposure of impacted teeth.

To be considered as having high-level severe handicapping malocclusion and to qualify for level four orthodontic treatment, the client must have one of the following conditions:

- Non-functional full Class II bite relationship
- Non-functional full Class III bite relationship

**Transfer of Services**

Prior authorization that is issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new prior authorization to complete the orthodontic treatment that was initiated by the original provider.

The new provider must obtain their own records and the new request for orthodontic services must include the date of service on which the documentation was obtained (the date of service on which the records were produced) and the following supporting documentation:

- All of the documentation that is required for the original request
- The reason the client left the previous provider
- An explanation of the treatment status

**Orthodontic Cases Initiated through a Private Arrangement**

Authorization may be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement prior to becoming Medicaid eligible.

Authorization will not be given for continuation of orthodontic case for clients who initiated orthodontic treatment through a private arrangement while the client is Medicaid eligible at the start of service.

**Removal of an Appliance**

The premature removal of an appliance must be prior authorized if the appliance was placed by a different provider who has an unaffiliated practice (not a partner or part of an office-sharing arrangement) and one of the following must be documented:

- The client is uncooperative and or non-compliant with care of the appliance.
- The client requested the premature removal, and a release form has been signed by a parent or legal guardian, or by the client if he or she is 18 years of age or older.

The provider must obtain written consent on a release form signed and dated by the requesting parent and/or client for premature removal of orthodontic appliances (bands,

brackets, etc.). The provider must maintain this documentation in the client's dental record. This documentation must be made available upon request of Medicaid or its designee.

**Reimbursement**

All orthodontic treatment dentition procedure codes are comprehensive and include, but not limited to, all of the following:

- Pre and post records
- Banding of the maxillary teeth
- Banding of the mandibular teeth
- Monthly visits
- Retention appliances
- Head gear and other treatment appliances
- The placement/replacement of all brackets/bands/wires whether lost or lose
- Removal of brackets/bands/appliances upon completion of orthodontic treatment
- Initial retention appliances
- Initial follow-up retention appliance adjustment visits

The following are procedure codes that may be submitted for the level of orthodontic service or orthodontic appliances.

| Level One Procedure Codes | | | |
|---|---|---|---|
| D8010 | D8020 | D8210 | D8220 |
| Level Two Procedure Codes | | | |
| D8050 | | D8060 | |
| Level Three Procedure Codes | | | |
| D8070 | | D8080 | |
| Level Four Procedure Codes | | | |
| D8090 | | | |
| Orthodontic Appliances | | | |
| D8680 | D8691 | D8692 | D8693 |

Crossbite therapy is an inclusive charge for treating the crossbite to completion. Adjustments and maintenance are not reimbursed separately.

Rebonding or recementing and/or repair, as required, of fixed retainers may be reimbursed as medically necessary. Documentation of medical necessity must be retained in the client's dental record.

Replacement retainer(s) (procedure code D8692) may be reimbursed as medically necessary. Documentation of medical necessity must be retained in the client's dental record. Retainer adjustments are not reimbursed separately.

Removal of the appliance (procedure code D8680) will be denied if billed by the any provider on the same date of service as orthodontic treatment (procedure codes D8010, D8020, D8050, D8060, D8070, D8080, D8090, and D8220).

Procedure code D8680 must be used for premature appliance removal with prior authorization.

## 8.2 Forms

**Forms Impacted** ☒ **Yes** ☐ **No**
**Is form currently on PA Portal?** ☐ Yes ☒ No
**Form Title:** New forms created for Orthodontic Services. These forms need to be placed on the portal. The forms are located in the Texas Health Steps (THSteps) Orthodontic Dental Services tracking document.

- Texas Health Steps (THSteps) Non -Surgical Orthodontic Prior Authorization form
- Texas Health Steps (THSteps) Surgical Orthodontic Prior Authorization form

Revise current THSteps Dental Mandatory Prior Authorization Request Form to remove the orthodontic request section.

## 8.3 Provider Manual Changes

### 19 Dental

- New orthodontic guidelines, update all of the orthodontic information

### 21 FQHC

- Remove end-dated procedure codes from benefits and limitation table

Add new procedure codes to benefits and limitation table

## 9. Post-Implementation Utilization Review

A Post – Implementation UR should be run: Procedure codes W-D8010, W-D8020, W-D8210, W-D8220, W-D8050, W-D8060, WD8070, W-D8080, W-D8090, W-D8691 and W-D8692

☒ 15 months after implementation and cover months 1 through 12

Key rationale and direction for Post UR: New Benefits.

# 10. Impacts to Other Programs

If applicable, identify other programs with cross issues such as ECI, SHARS or Family Planning.

## 10.1 Relationship to CHIP

CHIP must cover medically necessary items/services for CHIP clients.

## 10.2 Relationship to Medicaid or CSHCN

CSHCN Services Program Dental- Orthodontic Dental Services will be reviewed after Medicaid's policy is through the BMW process.

# 11. Notes

In this section, track extensions, required actions, or any other information that is specific to the policy or topic not covered elsewhere.

Table 11-A

| Notes | | |
|---|---|---|
| *Author* | *Note* | *Date* |
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