PROVIDER JOB AID – ORTHODONTICS

Orthodontic Treatment: Prior Auth & Claim Requirements

Comprehensive Orthodontic Treatment (D8080 / D8070 / D8090)

Age Requirement: Comprehensive orthodontic treatment must start before the 21st birthday with initial placement and insertion of fixed or removable orthodontic appliances

Documentation Required for Prior Authorization (PA) Request Submission:

- Panoramic Radiograph (PAN)
- Cephalometric Radiograph* (Ceph)
- Photos* (Intraoral, including lateral and occlusal views, and extraoral)
- HLD Index Form
- If applicable, Medical Necessity Narrative and Supporting Documentation

* - Either the Ceph or photos must include a measurement device such as a calibration ruler, wire of known length, embedded measurement device, Boley gauge, disposable ruler, or periodontal probe. If not clearly marked, please include a brief explanation to aid in establishing a scale.

Codes to include in PA Request Submission:

- D8080/D8070/D8090 (no date of service)
- D8660 (date of service required)

D8660 *Pre-Orthodontic records charge* is only paid if a comprehensive orthodontic PA request has been denied.

- D8660 is only payable with an associated D8080/D8070/D8090 PA request denial, with a frequency limitation of one per 6 months per provider or location.
- D8660 is not separately billable without a comprehensive or limited orthodontic PA request denial. If a pre-orthodontic visit does not result in a PA request submission (for example, because orthodontic treatment is not yet indicated due to the member's growth and development), providers may consider a different code such as D0140 or D9310 (see page 9 for more info).
- D8660 is not billable after D8080, D8070, D8090, D8670, or D8680 has been paid.
- Please note that payment for approved comprehensive orthodontic treatment is inclusive of the pre-orthodontic work-up and includes payment for any diagnostic radiographs or photographs. D8660 will be denied if the D8080/D8070/D8090 PA request is approved.

Do not include D8670 ***Periodic orthodontic treatment visit*** as part of the comprehensive orthodontic PA request.

- If the comprehensive orthodontic PA request is approved, 8 units of D8670 will be automatically approved.
- Once the approved D8080/D8070/D8090 has been billed, you can bill D8670 for each eligible quarter every 90 days up to 8 units until the 36-month PA expiration date.

Claims Submission:

- **D8080/D8070/D8090:** Use the date of service that fixed or removable orthodontic appliances are initially placed and inserted (comprehensive orthodontic treatment start date or "banding date").
- **D8670:** Starting 90 days after the initial banding date, submit D8670 every 90 days when at least one (1) eligible treatment date occurred during the 90-day period.
  - Payment for each unit of service (D8670) includes all periodic orthodontic treatment visits provided to the patient within a quarterly (90-day) billing period.
  - If no service is provided in any given billing quarter, the next eligible treatment date should be used as the date of service on the claim. The next quarterly unit of service (D8670) must then be billed at least 90 days from this date of service.
  - Submit separate claims for each quarterly unit of service (D8670).
  - D8670 claims will be processed based on the frequency limitation of one unit every 90 days, starting 90 days from the date of service of initial banding date. A maximum of 8 units may be billed within the 36-month period following approval of the comprehensive orthodontic PA request.
  - Providers must maintain actual treatment dates in their patient records. Providers are no longer required to include actual treatment dates in the claim Remarks or Notes.

3rd Year of Treatment (Extension Request)

When to Submit: After the authorization period has expired (36 months after the comprehensive orthodontic PA request was approved) and/or all eight (8) units of D8670 quarterly adjustments have been paid and additional adjustments are necessary.

Please note if the original 36-month authorization period has not yet expired, you may submit a request to extend the PA expiration date for any unused units of D8670 following the standard PA extension process.

Documentation Required for PA Request Submission:

- Medical Necessity Narrative
  - The narrative must justify the additional units, including an explanation of why the initially approved units were insufficient and an updated treatment plan for the case
  - Include the number of quarterly D8670 units being requested
- Supporting Documentation that shows treatment progress and status, such as:
  - Progress Photos
  - Progress Panoramic Radiograph (PAN)
  - Progress Cephalometric Radiograph (Ceph)

Codes to include in PA Request Submission:

- D8670 (no date of service)

Up to 4 additional units of D8670 may be requested. The number of units approved is subject to consultant review based on the medical necessity and supporting documentation submitted.

- Approved units of D8670 can be billed for each eligible quarter every 90 days until the 36-month PA expiration date.

Claims Submission:

- **D8670:** Submit D8670 every 90 days when at least one (1) eligible treatment date occurred during the 90-day period.
  - Payment for each unit of service (D8670) includes all periodic orthodontic treatment visits provided to the patient within a quarterly (90-day) billing period.
  - If no service is provided in any given billing quarter, the next eligible treatment date should be used as the date of service on the claim. The next quarterly unit of service (D8670) must then be billed at least 90 days from this date of service.
  - Submit separate claims for each quarterly unit of service (D8670).
  - Approved units of D8670 can be billed once every 90 days over 36 months from the comprehensive orthodontic treatment PA extension approval.
  - Providers must maintain actual treatment dates in their patient records. Providers are no longer required to include actual treatment dates in the claim Remarks or Notes.

Retention (D8680)

Retention is reimbursed separately and includes removal of appliance (de-banding), construction and delivery of retainers, and follow up visits. Prior authorization is not required.

Claims Submission:

- **D8680:** Start with date of service that orthodontic appliances are removed and then submit for each subsequent visit that is needed to fabricate and deliver retainers and follow-up on retention.
  - Submit for reach retention visit with the actual date of visit on each claim.
  - Submit separate claims for each retention visit (D8680).
  - Up to a maximum of 5 units over 24 months after the first D8680 retention visit ("de-banding").

Replacement Retainer (D8703 / D8704)

Age Requirement: Replacement retainers are only covered for members 8-20 years old. Replacement retainers are not a covered service for members 21 years or older, regardless of whether comprehensive orthodontic treatment started before the 21st birthday.

Documentation Required for PA Request Submission:

- Medical Necessity Narrative including retention start date and reason for replacement

Codes to include in PA Request Submission:

- D8703 (upper) and/or D8704 (lower) (no date of service)

Claims Submission:

- **D8703 / D8704**: Use date of service that replacement retainer(s) are delivered.

Limited Orthodontic Treatment – Phase I (D8010 / D8020 / D8030 / 8040)

Age Requirement: Limited orthodontic treatment must start before the 21st birthday with initial placement and insertion of fixed or removable orthodontic appliances

Documentation Required for PA Request Submission:

- Medical Necessity Narrative
  - Narrative must establish that limited orthodontic treatment is medically necessary to prevent or minimize the development of a handicapping malocclusion or will preclude the need for comprehensive orthodontic treatment.
  - Include the number of adjustment visits required in conjunction with the type of limited orthodontic appliance.
- If applicable, Supporting Documentation, such as:
  - Panoramic Radiograph (PAN)
  - Cephalometric Radiograph (Ceph)
  - Photos

Codes to include in PA Request Submission:

- D8010/D8020/D8030/8040 (no date of service)
- D8660 (date of service required)

D8660 *Pre-Orthodontic records charge* is only paid if a limited orthodontic PA request has been denied.

- D8660 is only payable with an associated D8010/D8020/D8030/8040 PA request denial, with a frequency limitation of one per 6 months per provider or location.
- D8660 is not separately billable without a comprehensive or limited orthodontic PA request denial. If a pre-orthodontic visit does not result in a PA request submission (for example, because orthodontic treatment is not yet indicated due to the member's growth and development), providers may consider a different code such as D0140 or D9310 (see page 9 for more info).
- D8660 is not billable after D8080, D8070, D8090, D8670, or D8680 has been paid.
- Please note that payment for approved limited orthodontic treatment is inclusive of the pre-orthodontic work-up and includes payment for any diagnostic radiographs or photographs. D8660 will be denied if the D8010/D8020/D8030/8040 PA request is approved.

Do not include D8999 (limited orthodontic adjustment visits) as part of the limited orthodontic PA request.

- If the limited orthodontic PA request is approved, 5 units of D8999 will be automatically approved.
- Once the approved D8010/D8020/D8030/8040 has been billed, you can bill D8999 up to 5 units until the 36-month PA expiration date.

Claims Submission:

- **D8010/D8020/D8030/D8040**: Use date of service that fixed or removable orthodontic appliances are initially placed and inserted (limited orthodontic treatment start date or "banding date").
- **D8999**: Submit for each adjustment visit with the actual date of visit on each claim.
  - Submit separate claims for each adjustment visit (D8999).
  - Up to a maximum of 5 units over 36 months from the limited orthodontic treatment PA approval

Continuation of Care (COC)

Age Requirement: Continuation of Care must be approved before the 21st birthday. Members 21 years or older are not eligible for COC.

When to Submit: If a member is already undergoing comprehensive or limited orthodontic treatment and is transferring from another provider, state Medicaid program, or other dental payor, the MassHealth provider that seeks to continue the treatment must submit a PA request for continuation of care.

Please note that members who have previously received a clinical denial from the MassHealth Dental program for a comprehensive or limited orthodontic PA request are not eligible for continuation of care.

Documentation Required for PA Submission:

- The treatment plan and anticipated number of adjustments needed for completion.
- Continuation of Care (COC) form (See Appendix A of the ORM for a copy)
- HLD Form (if possible)
- Photos
- Panoramic Radiograph (PAN)

Codes to include in PA Request Submission:

- D8670 or D8999 (no date of service)

Up to 8 units of D8670 may be requested for continued comprehensive orthodontic treatment and up to 5 units of D8999 for continued limited orthodontic treatment. The number of units approved is subject to consultant review based on the medical necessity and supporting documentation submitted.

- Approved units of D8670 or D8999 can be billed until the 36-month PA expiration date.

Claims Submission:

- **D8670:** Submit D8670 every 90 days when at least one (1) eligible treatment date occurred during the 90-day period.
  - Payment for each unit of service (D8670) includes all periodic orthodontic treatment visits provided to the patient within a quarterly (90-day) billing period.
  - If no service is provided in any given billing quarter, the next eligible treatment date should be used as the date of service on the claim. The next quarterly unit of service (D8670) must then be billed at least 90 days from this date of service.
  - Submit separate claims for each quarterly unit of service (D8670).
  - Approved units of D8670 can be billed once every 90 days over 36 months from the comprehensive orthodontic treatment COC PA approval.
  - Providers must maintain actual treatment dates in their patient records. Providers are no longer required to include actual treatment dates in the claim Remarks or Notes.
- **D8999**: Submit for each adjustment visit with the actual date of visit on each claim.
  - Submit separate claims for each adjustment visit (D8999).
  - Approved units of D8999 can be billed over 36 months from the limited orthodontic treatment COC PA approval

Helpful Reminders

- When D8080/D8070/D8090 is approved, 8 units of D8670 are also approved.
- When D8010/D8020/D8030/D8040 is approved, 5 units of D8999 are also approved.
- If the comprehensive or limited orthodontic PA expires before all 8 units of D8670 or 5 units of D8999 have been rendered, an extension PA request must be submitted.
- Providers do not need to include PA # in the Remarks or Notes section when submitting claims for approved services – except for DentaQuest-issued approvals for D8080/D8070/D8090, D8010/D8020/D8030/D8040, or D8703/D8704. DentaQuest-issued PA approvals will be honored until their expiration date. The DentaQuest PA# must be submitted with the claim in the Remarks section. If available, please include the PA approval letter to expedite claims processing. For D8670 or D8999 claims, the DentaQuest PA# does not need to be submitted.
- D8670 can only be billed when at least one (1) eligible treatment date occurred during the 90-day period.
- Providers may not bill members for broken, repaired, or replacement brackets or wires, and may not charge members "appointment" or "retainer" fees to set appointments regardless of if the fee is ultimately refunded to the member.
- Providers are encouraged to treat Class III malocclusions with the appropriate limited orthodontic treatment and may submit for approval of both limited and comprehensive treatment of Class III malocclusions at the time limited treatment is necessary.
- D8999 and D8680 are limited to 5 per patient per lifetime.
- If a member under 21 years old needs to discontinue orthodontic treatment for reasons other than completion of treatment, providers should submit a non-covered PA request under EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) for D8695 to remove the fixed orthodontic appliances.
- Non-covered services include services for which prior authorization has been denied and deemed not medically necessary. A provider may charge an eligible MassHealth member for orthodontic services for which prior authorization has been denied and deemed not medically necessary only if the member knowingly elects to receive the services, understands the availability of covered services, and enters into a written agreement to pay for such services prior to receiving them.
- Children's Medical Security Plan (CMSP) coverage does not include orthodontic services. Providers may charge CMSP members for non-covered orthodontic services without receiving a PA denial so long as the member knowingly elects to receive the services, understands the availability of covered services, and enters into an agreement in writing to pay for such services prior to receiving them.
- Unlike D8660 *Pre-Orthodontic records fee* which is only paid when a comprehensive or limited orthodontic PA request has been denied, D0140 *Limited oral evaluation - problem focused* and D9310 *Consultation- Diagnostic service provided by dentist or physician other than requesting dentist or physician* do not require a PA request to be submitted or denied.
- Cephalometric, panoramic, and other radiographs are included in payment for orthodontic services and are not separately billable when required for orthodontic diagnosis.

Questions?

Email ProviderRelations@massdhp.com, call 844-MH-DENTL (844) 643-3685, or visit massdhp.org.