AmeriHealth Caritas
District of Columbia

To:	AmeriHealth Caritas DC Dental Providers
Date:	February 4, 2021
Subject:	**Orthodontic services for enrollees ages 0 – 20**

The Dental Supplemental Provider Manual is undergoing a revision to include specific verbiage from the DC Register's orthodontic portion of 29DCMR 964 under the Notice of Final Rulemaking. All authorization submissions should take into account the full provisions cited in the update as of the date of this notice. Please contact Kelli Johnson at 202-408-3968 for questions in regard to this matter.

Orthodontic services for enrollees ages 0 – 20.

Medicaid enrollees age 20 and younger may qualify for orthodontic care under the District of Columbia Medicaid program. Enrollees must have a severe, dysfunctional, handicapping malocclusion. Since a case must be dysfunctional to be accepted for treatment, enrollees whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations.

All orthodontic services require prior authorization by an AmeriHealth Caritas DC dental consultant. The enrollee should present with a fully erupted set of permanent teeth. At least ½ to ¾ of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.

There are three avenues for orthodontic coverage:

1. Having a minimum score on the Handicapping Labio-Lingual Deviation (HLD) index of 15 or greater
2. Exhibiting one of six automatic qualifying conditions
3. Otherwise established a medical need for orthodontic treatment by demonstrating two (2) or more of the conditions below and justified the need in an accompanying narrative prepared by the ordering or referring dentist, orthodontist, primary care physician, speech pathologist, or behavioral health provider:
    a. A speech pathology that has proven non-responsive to medical treatment without orthodontic treatment, which has been diagnosed by a licensed speech therapist;
    b. Dysfunctional masticatory capacity as a result of the existing relationship between the maxillary and mandibular arches;

c. Significant facial asymmetry;
d. Severe maxillary, mandibular, or bi-maxillary protrusion or other physical deviation; or
e. Other conditions that affect the medical, social, or emotional function of the patient as demonstrated by objective evidence provided by the patient's primary care physician or behavioral health provider

Before delivering an orthodontic service, each provider shall request prior authorization. To be eligible for orthodontia services, the beneficiary's dental or orthodontia provider shall demonstrate that the beneficiary meets at least one of the following criteria:

1. An enrollee must have an HLD score greater than or equal to 15
2. An enrollee must exhibit one or more of the following automatic qualifying conditions that cause dysfunction due to a handicapping malocclusion and are supported by evidence in the beneficiary's treatment records:
    a. Cleft palate deformity
    b. Cranio-facial anomaly
    c. Deep impinging overbite
    d. Crossbite of individual anterior teeth
    e. Severe traumatic deviation
    f. Overjet greater than 9 mm or mandibular protrusion greater than 3.5 mm

The following documentation must be submitted with the request for prior authorization services:

- ADA 2012 or newer claim form with service code requested
- Five to seven diagnostic-quality photos
- Cephalometric head film with measurements
- Panoramic or full series periapical radiographs
- Clinical summary with diagnosis
- HLD score sheet completed and signed by the orthodontist
- Treatment plan

Treatment should not begin prior to receiving notification from AmeriHealth Caritas DC indicating coverage or non-coverage for the proposed treatment plan. Orthodontists who begin treatment before receiving their approved (or denied) prior authorization are financially obligated to complete treatment at no charge to the enrollee or face possible termination of their Participating Provider Agreement. Providers cannot bill prior to services being performed. The starting and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the enrollee's mouth. The initial payment for orthodontics

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(code D8080) includes initial banding, de-banding, one set of retainers, and adjustments (the number of adjustments depends on the plan).

To guarantee proper and prompt payment of orthodontic cases, please follow the steps below:

- Submit a completed ADA 2012 (or newer) claim for pre-authorization of comprehensive orthodontic treatment listing D8080 (comprehensive orthodontic treatment), D8660 (orthodontic records), and D8670 (periodic orthodontic treatment visits). Please note that, if an appliance is medically necessary, you should include D8220 (fixed appliance therapy) and/or D8210 (removable appliance therapy) in the prior authorization request with information related to which arch the appliance will be placed at and the medical necessity for the appliance.
- Once the determination has been made on the comprehensive orthodontic treatment, submit a separate claim for reimbursement of records (D8660) with the date records were taken. D8660 will only be paid in conjunction with comprehensive orthodontic treatment (D8080).
- When brackets and bands have been placed in the enrollee's mouth, submit a separate claim for reimbursement for comprehensive orthodontic treatment (D8080) with the banding date
- When the habit appliance is placed in the enrollee's mouth, submit a separate claim for reimbursement of the habit appliance (D8220 or D8210)
- Providers must submit claims for periodic treatment visits (D8670). The enrollee must be eligible on each date of service.
- Electronically file, fax, or mail a copy of the completed ADA form with the date of service filled in. Our fax number is **262-241-7150**.

The maximum case payment for orthodontic treatment is:

- One records fee (D8660)
- One initial payment (D8080)
- One appliance (D8220), if medically necessary
- One removable appliance (D8210), if medically necessary
- Twenty-one monthly adjustments submitted (D8670)
- Two orthodontic retentions (D8680)
- Additional periodic treatment visits beyond 21 monthly adjustments will be the provider's financial responsibility and not the enrollee's
- Enrollees may not be billed for broken, repaired, or replacement brackets or wires