14.00 Clinical Criteria

The criteria outlined in the Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association’s Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as guidelines for authorization and payment decisions and are not intended to be all-inclusive or absolute. Additional narrative information is appreciated when there may be a special situation.

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that “local community standards of care” may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. We share your commitment and belief to provide quality care to Members and we appreciate your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in your particular program. In addition, there may be additional program specific criteria regarding treatment. Therefore it is essential you review the Benefits Covered Section before providing any treatment.

14.01 Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for authorization procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.

- Treatment rendered under emergency conditions, when authorization is not possible, requires that appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

- Narrative demonstrating medical necessity.

Criteria

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.

- Alveoloplasty (code D7310) in conjunction with three or more extractions in the same quadrant will be covered subject to consultant review.
14.02 Criteria for Cast Crowns

Documentation needed for authorization of procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent anterior teeth.
- Cast Crowns on permanent teeth are expected to last, at a minimum, five years.

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
• Tooth is a primary tooth.
• Crowns are being planned to alter vertical dimension.

14.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure:
• Sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.
• Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:
• Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist’s ability to fill the canal to the apex.
• Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for Root Canal therapy will not meet criteria if:
• Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
• The general oral condition does not justify root canal therapy due to loss of arch integrity.
• Root canal therapy is for third molars, unless they are an abutment for a partial denture.
• Tooth does not demonstrate 50% bone support.
• Root canal therapy is in anticipation of placement of an overdenture.
• A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.
Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.

- In cases where the root canal filling does not meet treatment standards, we can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after we review the circumstances.

14.04 Criteria for Stainless Steel Crowns

In most cases, authorization is not required. Where authorization is required for primary or permanent teeth, the following criteria apply:

Documentation needed for authorization of procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.

- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

- Narrative demonstrating medical necessity if radiographs are not available.

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.

- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.

- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.

- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.

- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist’s ability to fill the canal to the apex.
• The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

• The patient must be free from active and advanced periodontal disease.
• The permanent tooth must be at least 50% supported in bone.
• Stainless Steel Crowns on permanent teeth are expected to last five years.

Authorization and treatment using Stainless Steel Crowns will not meet criteria if:

• A lesser means of restoration is possible.
• Tooth has subosseous and/or furcation caries.
• Tooth has advanced periodontal disease.
• Tooth is a primary tooth with exfoliation imminent.
• Crowns are being planned to alter vertical dimension.

14.05 Criteria for Authorization of Operating Room (OR) Cases

Documentation needed for authorization of procedure:

• Treatment Plan (prior-authorized, if necessary).
• Narrative describing medical necessity for OR.

All Operating Room (OR) Cases Must be Authorized.

Provider should submit services to administrator for authorization. Upon receipt of approval from administrator, Provider should contact Health Plan for facility authorization at the number below.

Neighborhood Health Plan: 866.414.5533
Criteria

In most cases, OR will be authorized (for procedures covered by Health Plan) if the following is (are) involved:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.

- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, resent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).

- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during extensive dental procedures.

- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate.

- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.

- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

14.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure:

- Treatment plan.

- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panorex.

- Treatment rendered without necessary authorization will still require appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

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Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.

- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.

- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.

- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.

- The replacement teeth should be anatomically full sized teeth.

Authorizations for Removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.

- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.

- If there are untreated cavities or active periodontal disease in the abutment teeth.

- If abutment teeth are less than 50% supported in bone.

- If the recipient cannot accommodate and properly maintain the prosthesis (i.e., Gag reflex, potential for swallowing the prosthesis, severely handicapped).

- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.

- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.

- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.
Criteria

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.

- Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed:
  - Adjustments will be reimbursed at one per calendar year per denture.
  - Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
  - Relines will be reimbursed once per denture every 36 months.
  - A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
  - Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for pre-authorization of a new denture.

- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.

- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.

- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

14.07 Criteria for the Excision of Bone Tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal of tori (mandibular and palatal) is an appropriate course of treatment prior to prosthetic treatment.

Code D7471 (CDT–4) is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Documentation needed for authorization of procedure:
Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapicals or panorex.

Treatment plan – includes prosthetic plan.

Narrative of medical necessity, if appropriate.

Study model or photo clearly identifying the lateral exostosis (es) to be removed.
14.08 Criteria for the Determination of a Non-Restorable Tooth

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient’s needs.

14.09 Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

Requests for general anesthesia or IV sedation will be authorized (for procedures covered by Health Plan) if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of impacted or unerupted cuspids.
- Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down’s syndrome) which would render patient non-compliant.

- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.

- Patients 3 years old and younger with extensive procedures to be accomplished.

14.10 Criteria for Periodontal Treatment

Not all procedures require authorization. Documentation needed for authorization of procedure:

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.
- Treatment plan.

Periodontal scaling and root planing, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:

“Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic.”

Criteria

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally at least one of the following must be present:
  1) Radiographic evidence of root surface calculus.
2) Radiographic evidence of noticeable loss of bone support.

15.00 Orthodontia

Members under age 19 may qualify for orthodontic care under the NHP Dental program. Members must have a severe and handicapping malocclusion. All orthodontic services require prior authorization with the exception of pre-orthodontic treatment visits and orthodontic retention.

Members age 19 and older may qualify for continuation of orthodontic care under the NHP Dental program. Members must have been banded prior to their 19th birthday and remain eligible for NHP dental benefits after age 19 to continue treatment.

15.01 Authorization for Treatment – Comprehensive Orthodontia

1. Provider performs orthodontic evaluation to determine if orthodontic treatment is necessary.

2. Submit all applicable completed forms and documentation to administrator for review. (See Required Forms below...2a – 2e)
   a. 2006 ADA Form requesting authorization
      i. Providers will be allowed to request the 1st two years of treatment in one authorization by doing the following
         1. Request authorization for D8080
         2. Request authorization for 8 units of D8670
         3. Enter Pre-Orthodontic records charge (D8690) with date of service. If Authorization for D8080 is denied, code D8690 will be processed with the date of service entered on the Authorization.
   b. Orthodontics Prior Authorization Form
      i. The Orthodontics Prior Authorization is available to record information regarding exceptional cases where the HLD Index score does not reflect the overall severity of the patient's condition due to the presence of other severe deviations. In such cases, if the severe deviations are left untreated, irreversible damage to the teeth and underlying structures would occur. Examples of such deviations include the presence of clefts and facial asymmetry.
   c. Orthodontic HLD Form
      i. The minimum HLD Score to be considered for approval of medically necessary orthodontic treatment is 28.
   d. Photographic Prints to include Lateral and Occlusal views and Radiographs.
      i. Models are not required for consideration of prior authorizations for orthodontic treatment.
   e. Continuation of Care Form (If applicable)

3. If prior authorization is DENIED...
   a. Administrator will send the provider and member a denial notice in the mail and post the denial to the Provider Web Portal.
   b. Administrator will assign an authorization for D8690 to cover pre-orthodontic work-up that includes payment for any diagnostic radiographs or photographs and adjudicate using the date of service submitted on the authorization.

4. If comprehensive orthodontic treatment is APPROVED,
   Prior Authorization covers a maximum of two and one-half years of orthodontic treatment visits. The Prior Authorization will expire three years from the date of approval to provide you with time to complete treatment.
   a. Provider must make sure that the patient is banded prior to their 19th birthday.
   b. Provider must check eligibility on all dates of service to determine whether it will be an “eligible” service date.
c. Place the braces on the patient

5. Once banding is completed, the provider must follow the required billing rules and process guidelines for the 1st authorization period.
   a. Electronically file or mail a copy of the completed 2006 ADA claim form with the date of service (banding date) filled in. Initial payment for orthodontics (code D8080) includes pre-orthodontic visit, records, photographic prints, models and initial banding. Providers must submit a claim for the initial payment for code D8080 upon completion of banding.
   b. Providers must bill each quarter (D8670), no less than 90 days apart, as one unit of service and may bill for a quarter if they have at least one eligible treatment date in the quarter.
   c. Provider may not bill the first adjustment prior to 90 days from the date of banding.
      i. Provider should note the actual treatment dates in the notes section (box 35 of the 2006 ADA Claim form)
   d. The patient must be eligible on the date of service being billed for the claim to pay without review.
      i. If the patient is ineligible on the scheduled billing date, the provider must bill the last eligible treatment date as the date of service
      ii. We will review any orthodontic quarterly adjustments that deny for “frequency limitations exhausted” due to this occurrence to determine if the patient was eligible for services rendered during that quarter.
      iii. The provider would need to verify that the patient had an eligible treatment date during a paid quarter upon audit/request.
   e. The maximum payment to cover the 1st authorization period will be 8 units of quarterly adjustments (D8670 x 8).

6. Once the 1st authorization has expired or all 8 units of quarterly adjustments have been paid, the provider can apply for a 2nd authorization if continued adjustments are necessary.
   a. The provider can request up to one year of additional orthodontic treatment to complete the case.
   b. NHP/Administrator will evaluate the case based on the Orthodontic Prior Authorization Form, and provider narrative provided at the time the 2nd authorization is requested.
   c. Provider must only include a separate narrative of medical necessity in box 35 if requesting more than 2 units of continued adjustments (D8670)

7. If the 2nd authorization is APPROVED, then the provider can continue billing for the amount of adjustments that were approved to complete the case.
   a. The maximum payment for the completion of orthodontic treatment for the 2nd authorization will be 4 units.
   b. If the provider does not request the maximum number of units upon initial request for the 2nd authorization, they may request additional units until the maximum number of units (4) are approved and exhausted.
   c. If the Authorization expires prior to the completion of treatment, you may request an extension
      i. Extension requests must be submitted in writing to the authorization department and must include the authorization number.
   d. Retention
      i. Retention is reimbursed separately and includes removal of appliances (debanding), construction and delivery of retainers, and follow up visits.
      ii. The maximum number of reimbursable retention visits (post-treatment stabilization) is five.
      iii. Prior authorization is not required for retention.
      iv. If the patient loses or breaks his/her retainers, the provider must submit for prior authorization and receive approval prior to completing the repair or replacing the retainers.

Revised 1/22/2015
8. **Miscellaneous Orthodontic Rules**
   a. Members may not be billed for broken, repaired, or replacement of brackets or wires.
      a. If no service is provided in any given billing quarter, the next eligible treatment date should be used as the date of service and the 90-day waiting period will reset once a new date is established

15.02 **Authorization Determination**

The prior authorization approval for initial orthodontics, (D8080) and first two (2) years of treatment (D8670 x 8 units) will expire three (3) years from the date of the authorization. Approval for the third year of orthodontics will be valid for twelve to eighteen (12-18) months, depending on the number of units requested.

If the case is denied, a determination notice will be sent to the provider indicating that the orthodontic treatment will not be covered. However, an authorization will be issued for the payment of code D8690, to cover pre-orthodontic work-up that includes payment for treatment plan, radiographs, diagnostic prints and/or photos orthodontic records, and diagnostic models. Payment for D8690 will only be allowed for comprehensive treatment cases submitted as D8080.

15.03 **Continuation of Care**

Administrator requires the following information for possible payment of continuation of care cases:

A. 2006 ADA claim form listing services to be rendered.
B. Orthodontics Prior Authorization Form (page B-1 from the ORM).
C. Orthodontic HLD form (page B-4 and B-5 from the ORM).
D. Continuation of care form (page B-9 from the ORM).
E. Copy of the member’s prior approval including approved service codes and fees.
F. If service was previously approved by administrator, a letter from previous doctor to transfer the patient’s authorization to the new dentist (only if current authorization has not expired or been consumed).

It is the Provider’s and Member’s responsibility to obtain and submit the required information. Cases can not be authorized for possible payment without complete information.

15.04 **Interceptive Orthodontic Treatment**

1. Provider performs orthodontic evaluation to determine if orthodontic treatment is necessary.
2. Provider should submit a 2006 ADA Form requesting authorization along with a narrative of medical necessity to the administrator in the following manner.
   a. Include the code for the appliance being used (D8050 and D8060)
   b. Include the code and the number of treatment visits you are requesting for adjustments (D8999) up to a maximum of 5.
3. If prior authorization is DENIED…
   a. The administrator will send the provider and member a denial notice in the mail and post the denial to the Provider Web Portal.
4. If prior authorization is APPROVED…
   a. Provider can place the appliance for the patient.
   b. Provider can bill for the appliance (D8050 or D8060) once the appliance is placed.
   c. Provider can bill for the number of adjustments (D8999) performed, up to a maximum of 5, using the actual dates of treatment as the date of service.
This can be billed weekly, monthly, quarterly, etc until all 5 units are exhausted.

5. When submitting for interceptive treatment please note that documentation supporting at least one of the following is necessary:

- Cleft Palate
- Crossbite of individual anterior teeth
- Posterior Crossbite
- Severe Traumatic Deviations (loss of premaxilla segment by burns or accident; the result of osteomyelitis or gross pathology)

When submitting for interceptive treatment please note that documentation supporting at least one of the following is necessary:

- Cleft Palate
- Crossbite of individual anterior teeth
- Posterior Crossbite
- Severe Traumatic Deviations (loss of premaxilla segment by burns or accident; the result of osteomyelitis or gross pathology)

15.05 General Billing Information for Orthodontics

The start and billing date of orthodontic services is defined as when the bands, brackets, or appliances are placed in the member’s mouth. The member must be eligible on this date of service and the member must be under age 19.

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

- Electronically file or mail a copy of the 2006 ADA claim form with the date of service (banding date) filled in. Initial payment for orthodontics (code D8080) includes the pre-orthodontic visit, records, photographic prints, radiographs, and initial banding. Providers must submit a claim for code D8080 upon completion of banding.

- Providers must bill each quarter (D8670), no less than 90 days apart, as one unit of service and may bill for a quarter if they have at least one eligible treatment date in the quarter. Provider should note the actual treatment dates in the notes section of the claim form (box 35 of the 2006 ADA claim form). Provider may not bill the first quarterly adjustment prior to 90 days from the date of banding.

- The member must be eligible on the date of service being billed for the claim to pay without review. If the member is ineligible on the scheduled billing date, the provider must bill the last eligible treatment date as the date of service for payment review.

- 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 following quarterly adjustment (D8670) should be billed no less than 90 days from this date of service.

Members may not be billed for broken, repaired, or replacement brackets or wires.

Retention is reimbursed separately and includes removal of appliances (debanding), construction and delivery of retainers, and follow up visits. The maximum number of reimbursable retention visits (post-treatment stabilization) is five (5). Prior authorization is not required.
Please notify the administrator should the member discontinue treatment for any reason.