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Related Clinical Coverage Policies
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policy listed below:
4A Dental Services

1.0 Description of the Procedure, Product, or Service

Orthodontics is defined as a corrective procedure for functionally impairing occlusal conditions (including craniofacial abnormalities and traumatic or pathologic anatomical deviations) that cause pain or suffering, physical deformity, significant malfunction, aggravates a condition, or results in further injury or infirmity. Such services must maintain a high standard of quality and must be within the reasonable limits of services customarily available and provided to most persons in the community with the limitations and exclusions specified in this policy. **Only the procedure codes listed in this policy are covered under the North Carolina (NC) Medicaid (Title XIX) Dental Program**.

NC Medicaid has adopted procedure codes and descriptions as defined in Section 1, Code on Dental Procedures and Nomenclature (CDT Code), of the *CDT 2020 Dental Procedure Codes* published by the American Dental Association (ADA).

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>

None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: https://medicaid.ncdhhs.gov/

2.3 Limitations

Pregnant Medicaid eligible beneficiaries covered under the Medicaid for Pregnant Women program class "MPW" and beneficiaries covered under the Family Planning Waiver program class "MAFD" are not eligible for orthodontic services as described in this policy. Beneficiaries covered under the Medicare Qualified Beneficiaries program class "MQB" do not receive a Medicaid card and the only benefit that the beneficiary receives from Medicaid is the payment of the Medicare premium. The beneficiary is not eligible for any orthodontic services as described in this policy. Beneficiaries enrolled with the Program of All-Inclusive Care for the Elderly (PACE) are not covered for orthodontic services as described in this policy. Providers shall ask beneficiaries for their PACE card and contact the PACE program for information regarding benefits. Refer to **Subsection 5.3, Limitations or Requirements** for eligibility limitations for individual procedure codes.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply.

3.2.2 Medicaid Additional Criteria Covered

The following criteria for functionally impairing occlusal conditions apply when cases are reviewed for Medicaid orthodontic approval. The probability for approval is increased when **two or more** of the following criteria exist:

a. Severe skeletal condition that may require a combination of orthodontic treatment and orthognathic surgery to correct (beneficiary's age and the direction of growth are also considered);
b. Severe anterior-posterior occlusal discrepancy (severe Class II or Class III dental malocclusion);
c. Posterior crossbite of three or more teeth per arch;
d. Anterior crossbite of three or more teeth per arch;

e. True anterior open bite: 2 mm or more; of four or more teeth per arch;
f. Significant posterior open bite: 2 mm or more; of four or more teeth per arch (not involving primary teeth, partially erupted teeth, or one or two teeth slightly out of occlusion);
g. Impinging overbite with evidence of occlusal contact into the opposing soft tissue (lower incisors must be causing tissue trauma);
h. Overjet (excessive protrusion 6 mm or greater);
i. Crowding greater than 6 mm in either arch that must be moderate to severe and functionally intolerable over a long period of time (such as occlusal disharmony or gingival recession secondary to severe crowding);
j. Impactions where eruption is impeded with a good prognosis of being brought into the arch;
k. Excessive spacing of 10 mm or more, in either the maxillary or mandibular arch (excluding third molars), or 8 mm or greater from mesial of cuspid to mesial of cuspid. Any space that will remain for prosthodontic or implant replacement cannot be included in the measurements for meeting spacing criteria;
l. Two or more congenitally missing teeth (excluding third molars) of at least one tooth per quadrant;
m. Occlusal condition that exhibits a profound impact from a congenital or developmental disorder (craniofacial anomaly), severe trauma, or pathology;
n. Psychological and emotional factors causing psychosocial inhibition to the normal pursuits of life (requires supporting documentation of pre-existing condition from a licensed mental health professional specializing in child psychology or child psychiatry); or
o. Potential that all problems will worsen.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Orthodontic services are not covered when the criteria specified in **Section 3.0** and **Section 5.0** of this policy have not been met.

4.2.2 Medicaid Additional Criteria Not Covered

Orthodontic services are not covered when the above medical criteria are not met. Additionally, the following types of cases are not eligible for approval:

a. Interceptive or Phase I treatment cases of the primary and transitional dentition except for cases involving functionally impairing malocclusions caused by cleft lip and palate or other severe craniofacial developmental anomalies or severe traumatic injuries;
b. Minor tooth movement cases requiring a relatively short treatment period (less than 12 months);
c. Cuspid impactions with a poor prognosis of being brought down into occlusion in the presence of no other significant problems;
d. Bilateral or unilateral posterior crossbites of moderate severity without a significant mandibular shift or history of temporomandibular dysfunction and a lack of other significant problems;
e. Class I malocclusions with moderate crowding, no crossbites, overbite and overjet within normal limits;
f. Simple space closure of mild to moderate anterior spacing;
g. Simple one arch treatment;
h. Localized tooth alignment problems requiring a relatively short period of treatment (such as simple anterior or posterior crossbites, diastema closure, rotations);
i. Orthodontic treatment begun prior to the patient becoming eligible for Medicaid;
j. Habit appliance therapy;
k. Occlusal guard (including splint therapy for the treatment of temporomandibular dysfunction); and
l. Orthodontic treatment started as a private pay arrangement before Medicaid approval is requested.

If a non-covered orthodontic service is deemed medically necessary and warrants consideration of approval, the provider shall submit a prior approval request along with a letter describing the special circumstances of the case and appropriate orthodontic records. (Refer to **Subsection 5.9, Request for Medicaid Special Approval of a Non-Covered Service or Service Outside the Policy Limitations,** for specific instructions on submitting a prior approval request.)

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Orthodontic services require prior approval. Prior approval does not guarantee payment. Beneficiary eligibility for the date of service must be verified before rendering treatment. Failure to obtain required prior approval before rendering a service shall result in denial of payment for that service. The orthodontic records must be obtained for each case and screened to determine that the case is functionally impairing. All radiographic images, photographic images and models must be of acceptable diagnostic quality or the case will be returned. When submitting a prior approval request for orthodontic treatment electronically, upload all records except for the models to the NCTracks Prior Approval Portal. The models must be mailed with the NC DHHS Prior Approval Health Services

Attachment Review Cover Sheet. When submitting by mail, all orthodontic prior approval information (ADA Dental Claim Forms, pretreatment narrative, radiographic images, photographic images and models) must be received in the same package for each beneficiary. Multiple cases can be sent in the same package. If all the information is not received in the same package, the case will be returned to the provider requesting the additional information.

Refer to **Attachment A** – **Orthodontic Billing Guide**, for additional information.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Voiding a Prior Approval

The provider may void an orthodontic prior approval within a four-year period of the effective date for **one** of the following reasons:

a. the beneficiary's treatment plan has changed significantly;
b. the prior approval period has expired before the service could be rendered; or
c. the beneficiary wishes to have the service rendered by another provider.

In such cases, the provider shall choose **one** of the following methods to accomplish the process:

a. Submit electronically in the NCTracks Prior Approval Portal by clicking on the "Void PA Request" button to void the entire request; or
b. Submit by mailing a printed copy of the approved prior approval request from NCTracks and marking "VOID" on specific detail lines to be voided. Send this copy to NCTracks or to the beneficiary's new dentist if requested.

Note: Do not void any detail lines in which payment has been received for that service.

5.3 Limitations or Requirements

By State legislative authority, NC Medicaid applies service limitations to CDT Codes as they relate to individual beneficiaries. These service limitations are applied without modification of the CDT procedure nomenclature. Limitations that apply to an entire category of service are described at the beginning of the appropriate subsection. Limitations that apply to an individual procedure code are indicated by an asterisk (*) beneath the description of that code. Claims for services that fall outside these limitations will be denied unless special approval is granted for services deemed medically necessary for a Medicaid beneficiary under 21 years of age. Refer to **Subsection 5.9, Request for Medicaid Special Approval of a Non-Covered Service or Service Outside the Policy Limitations.**

NC Medicaid has adopted procedure codes and descriptions as defined in Section 1, Code on Dental Procedures and Nomenclature (CDT Code), of the *CDT 2020 Dental Procedure Codes* published by the American Dental Association (ADA). *CDT 2020*

5.3.1 Orthodontic Records

It is essential that Medicaid eligibility be confirmed on the date that the orthodontic records are taken. If the beneficiary is not eligible, no payment will be issued.

Note: Medicaid shall not cover interceptive orthodontics. Therefore, professional judgment must be used to determine at what stage orthodontic records are taken.

Orthodontic records are a once in a lifetime service. Orthodontic records must be submitted for prior approval using the date the records were taken as the requested begin date in the NCTracks Prior Approval Portal. The orthodontic records must be requested on the same request as the request for prior approval of orthodontic treatment. Once approval is granted, the provider shall submit the claim for payment of the orthodontic records electronically to NCTracks. No prior approval is required for the comprehensive oral evaluation (D0150). The provider may file a claim for payment once the evaluation has been rendered.

Code	Description	PA Needed?
D0150	Comprehensive oral evaluation – new or established patient * Use as the initial exam for a beneficiary * Allowed as an initial exam once per billing provider per beneficiary	No
D0330	Panoramic radiographic image * Limited to beneficiaries age six and older * Allowed as part of the orthodontic records if the previous panoramic radiographic image is more than one year old * Once in a lifetime service as part of the orthodontic records * Not allowed on the same date of service as D0210	Yes
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis * Limited to beneficiaries under 21 years of age * Once in a lifetime service	Yes
D0470	Diagnostic casts * Limited to beneficiaries under 21 years of age * Once in a lifetime service * Study models must be properly occluded and trimmed with markings that identify the beneficiary's accurate occlusion * Print the NC DHHS Prior Approval Health Services Attachment Review Cover Sheet to include in the mailing package with the study models	Yes

Note: Diagnostic intraoral and extraoral photographic images are required as a component of the orthodontic records submitted for orthodontic prior approval. These images are deemed a standard of care by the American Association of Orthodontics (AAO) Committee on Medically Necessary Orthodontic Care.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and examples of a prior approval request and a claim for orthodontic records.

5.3.2 Comprehensive Orthodontic Treatment

Medicaid approval and reimbursement for comprehensive orthodontic treatment also includes any fixed or removable appliances necessary to complete the approved treatment including functional appliances (such as a Herbst appliance), palatal expanders, bite plates, holding arches, retainers, etc.

Code	Description	PA Needed?
D8070	Comprehensive orthodontic treatment of the transitional dentition * Limited to Medicaid beneficiaries under 21 years of age * Limited to functionally impairing malocclusions caused by an occlusal condition that exhibits a profound impact from a congenital or developmental disorder (craniofacial anomaly such as cleft lip and palate or other conditions caused by a syndrome), severe trauma, or pathology which effect the function of speech, chewing, or swallowing * Includes placement and monitoring of fixed or removable appliances such as a functional appliance necessary to initiate active treatment * Use for full banding including the placement of bands, brackets, and appliances necessary to initiate active treatment of the upper and lower arches * Once in a lifetime service * Prior approval of orthodontic services is granted for 36 months * Essential to confirm on each date of service that the beneficiary is still eligible under the same health plan (Medicaid) in which the approval was granted in NCTracks. If the beneficiary is not eligible and the health plan is not the same as approved, no payment will be issued * Once the banding has been paid, use for the maintenance visits for comprehensive orthodontic treatment of the transitional dentition * Allowed once per calendar month (for example, a patient seen for a comprehensive orthodontic treatment of the transitional dentition visit on any date in January would be eligible for the next visit on any date in February) * Not allowed for repair or replacement of broken or missing brackets, bands, or wires when no other maintenance treatment is rendered * Limited to 23 reimbursable maintenance visits * The banding and 23 maintenance visits constitute the total reimbursement for comprehensive orthodontic treatment and the provider is expected to complete any additional maintenance visits necessary to achieve an acceptable treatment outcome without further reimbursement	Yes
D8080	Comprehensive orthodontic treatment of the adolescent dentition * Limited to Medicaid beneficiaries under 21 years of age * Limited to functionally impairing malocclusions for Medicaid beneficiaries * Includes placement and monitoring of fixed or removable appliances such as a functional appliance necessary to initiate active treatment * Use for full banding including the placement of bands, brackets, and appliances necessary to initiate active treatment of the upper and lower arches * Once in a lifetime service	Yes

Code	Description	PA Needed?
	* Prior approval of orthodontic services is granted for 36 months * Essential to confirm on the date of banding that the beneficiary is still eligible under the same health plan (Medicaid) in which the approval was granted in NCTracks. If the beneficiary is not eligible and the health plan is not the same as approved, no payment will be issued	
D8670	Periodic orthodontic treatment visit * Limited to Medicaid beneficiaries under 21 years of age * Use for the maintenance visits for comprehensive orthodontic treatment of the adolescent dentition * Limited to functionally impairing malocclusions for Medicaid beneficiaries * Prior approval of orthodontic services is granted for 36 months * Allowed once per calendar month (for example, a patient seen for a periodic orthodontic treatment visit on any date in January would be eligible for the next visit on any date in February) * Not allowed for repair or replacement of broken or missing brackets, bands, or wires when no other maintenance treatment is rendered * Limited to 23 reimbursable maintenance visits * The banding and 23 maintenance visits constitute the total reimbursement for comprehensive orthodontic treatment and the provider is expected to complete any additional maintenance visits necessary to achieve an acceptable treatment outcome without further reimbursement * If the case is approved and the banding is paid, Medicaid will continue to pay for monthly maintenance visits regardless of eligibility	Yes
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) * Limited to Medicaid beneficiaries under 21 years of age * Once in a lifetime service * When comprehensive orthodontic treatment is complete, refer to **Subsection 7.5 - Orthodontic Case Completion**, for specific instructions * When comprehensive orthodontic treatment is terminated, refer to **Subsection 7.3 – Terminated Orthodontic Treatment**, for specific instructions	Yes

Note: When a case is approved for comprehensive orthodontic treatment, all fixed or removable appliances (including broken or lost brackets) necessary to complete the approved treatment are included in the Medicaid payment and the beneficiary must **not** be billed any additional charges.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information.

5.3.3 Combined Orthognathic Surgery and Comprehensive Orthodontic Treatment

The following orthodontic records are allowed for the initial consultation visit for combined orthognathic surgery and comprehensive orthodontic treatment.

Code	Description	PA Needed?
D0160	Detailed and extensive oral evaluation – problem focused, by report * Allowed for the initial consultation visit for combined comprehensive orthodontic treatment and orthognathic surgery	No
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector * These images include, but are not limited to: Lateral Skull; Posterior-Anterior Skull; Submentovertex; Waters; Reverse Tomes; Oblique Mandibular Body; Lateral Ramus	No
D0330	Panoramic radiographic image * Limited to beneficiaries age six and older * Allowed as part of the orthodontic records if the previous panoramic radiographic image is more than one year old * Once in a lifetime service as part of the orthodontic records * Not allowed on the same date of service as D0210	Yes
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis * Limited to beneficiaries under 21 years of age * Once in a lifetime service	Yes
D0470	Diagnostic casts * Limited to beneficiaries under 21 years of age * Once in a lifetime service * Study models must be properly occluded and trimmed with markings that identify the beneficiary's accurate occlusion * Print the NC DHHS Prior Approval Health Services Attachment Review Cover Sheet to include in the mailing package with the study models	Yes

When the patient is ready for surgery, additional records are needed as the interim records. These records must be submitted with the prior approval request for orthognathic surgery. NC Medicaid shall grant an override of the lifetime limit to allow payment for the additional records required for the surgery request.
Note: The same records are required for orthognathic surgery requests submitted on behalf of a beneficiary who initiated their orthodontic treatment through a private-pay arrangement.

Certain second surgeries (such as bilateral procedures) performed on the same date of service may be reimbursed at 50 percent of the maximum allowed rate.

Code	Description	PA Needed?
D7940	Osteoplasty – for orthognathic deformities	Yes
D7941	Osteotomy – mandibular rami	Yes
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	Yes
D7944	Osteotomy – segmented or subapical	Yes
D7945	Osteotomy – body of mandible	Yes
D7946	LeFort I (maxilla – total)	Yes
D7947	LeFort I (maxilla – segmented)	Yes

D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	Yes
D7949	LeFort II or LeFort III – with bone graft	Yes
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	Yes
D7955	Repair of maxillofacial soft and/or hard tissue defect	Yes

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information.

The following records are required when submitting a prior approval request for combined comprehensive orthodontic treatment of the adolescent dentition (D8080) and orthognathic surgery to correct a skeletal imbalance:

a. Diagnostic Casts;
    1. Trimmed to centric occlusion with markings that identify the beneficiary's accurate occlusion
    2. Bite registration required
    3. Description of centric relation-centric occlusion shifts greater than 2mm
b. Three Extraoral Photographic Images;
    1. Full face with patient at rest
    2. Right profile with patient at rest
    3. Full face with patient smiling as fully as possible
c. Five Intraoral Photographic Images;
    1. Maxillary occlusal view
    2. Mandibular occlusal view
    3. Right lateral view in centric occlusion
    4. Left lateral view in centric occlusion
    5. Frontal view in centric occlusion
d. Radiographic Images;
    1. Panoramic (labeled right and left)
    2. Lateral cephalometric with tracing and analysis (right lateral with teeth in occlusion and the patient in a relaxed lip posture)
    3. Posterior-anterior cephalometric if asymmetry is present
    4. Individual periapical films as needed for special diagnostic concerns
e. Treatment Plan; and
    1. Necessary extractions
    2. Pre-surgical orthodontic treatment goals with specific measurements in all three dimensions
    3. Pre-treatment lateral cephalometric predictions showing anticipated orthodontic and surgical movements and resulting soft tissue profile
    4. Estimated time to complete pre-surgical orthodontics
    5. Post-surgical orthodontic treatment goals and estimated time to complete treatment
    6. Retention plan
f. Consultation notes from the provider who will be rendering the orthognathic surgery services indicating agreement with the proposed treatment plan.

5.4 ADA-Approved Materials

Only dental materials accepted by the ADA Council on Scientific Affairs shall be accepted for use in the dental care of Medicaid beneficiaries. Specific use of these materials must follow the guidelines of the ADA Council on Scientific Affairs.

5.5 Orthodontic Review Board

The Orthodontic Review Board shall determine on a case-by-case basis whether to authorize coverage. If necessary, members of the review board shall physically examine the beneficiary before approval of the case. In reaching a decision, the functional need must be examined as well as other factors such as:

a. The beneficiary's attitude and ability to meet appointments.
b. The beneficiary's ability to follow instructions and cooperate through a lengthy treatment period.
c. The beneficiary's ability to maintain an acceptable level of oral hygiene vital to the success of treatment.

5.6 Notifications to the Provider

Once a decision is made regarding the request for orthodontic services, written notification is sent to the provider.

a. If the case is approved, the DHHS Utilization Review Contractor will send an electronic Notice of Decision to the provider through NCTracks and return all orthodontic records.
b. If the case is denied, the DHHS Utilization Review Contractor will send an electronic Notice of Decision to the provider through NCTracks and return all orthodontic records. A letter of notification of denial, along with appeal rights, is mailed to the beneficiary. A copy of the denial letter is also mailed to the provider.

5.7 Periodic Orthodontic Treatment (Maintenance) Visits

It is anticipated that the treatment period will be completed in 24 to 36 months after initial banding. Periodic orthodontic treatment (maintenance) visits are paid only once per calendar month with a total of 23 visits allowed (for example, a patient seen for a periodic orthodontic treatment visit on any date in January would be eligible for the next visit on any date in February).

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information.

5.8 Reimbursement of Orthodontic Maintenance Visits During Ineligible Periods

It is essential that Medicaid eligibility be confirmed on the date of banding. If the beneficiary is not eligible, no payment will be made. Only orthodontic periodic maintenance visits (D8670) for the comprehensive orthodontic treatment of the adolescent dentition (D8080) are reimbursed regardless of the beneficiary's eligibility status at that visit if the beneficiary was eligible on the date of banding and the payment is in paid history. The case must be approved before the initial banding takes place. Banding must occur before maintenance visits are billed.

Note: The beneficiary must be Medicaid eligible for reimbursement of the periodic maintenance visits for comprehensive orthodontic treatment of the transitional dentition (D8070) on each date of service.

No other services are covered during ineligible periods. Providers shall make the beneficiary aware that Medicaid will not pay for any routine care, restorative care,

extractions, or orthognathic surgery needed during orthodontic treatment if rendered during ineligible periods.

5.9 Request for Medicaid Special Approval of a Non-Covered Service or Service Outside the Policy Limitations

Dental providers may request special approval for a service that is non-covered by the NC Medicaid program or falls outside the limitations stated in this policy, if that service is deemed medically necessary for a Medicaid beneficiary under 21 years of age as described in **Subsection 2.2.1** of this policy. All such requests must be submitted and approved prior to delivery of the service. Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code of service being requested entered and indicate that the request is for special approval of a non-covered service in the "Documentation of Medical Necessity" field;
b. any materials needed to document medical necessity (such as radiographic and photographic images, dental and periodontal charting, a letter from the beneficiary's medical care provider); and
c. the completed Non-Covered State Medicaid Plan Services Request Form for Beneficiaries Under 21 Years of Age or a cover letter that documents how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. This includes documentation about how the service, product, or procedure will correct or ameliorate (improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems) as well as the effectiveness and safety of the service, product, or procedure.

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to:

NCTracks Prior Approval Unit
PO Box 31188
Raleigh, NC 27622

If the procedure(s) receives special approval and the beneficiary is Medicaid eligible on the date the service is rendered, the dentist then can file for reimbursement.

Note: A copy of the Non-Covered State Medicaid Plan Services Request Form for Beneficiaries Under 21 Years of Age can be found on the NCTracks Prior Approval page at https://www.nctracks.nc.gov/content/public/providers/prior-approval.html.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Note: All dental providers participating in the Medicaid programs shall provide services according to the rules and regulations detailed in this policy.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations
None Apply.

6.2 Provider Certifications
To obtain a dental specialty taxonomy, the provider shall submit proof of the residency program completion and a copy of the specialty certification to NC Medicaid with the initial enrollment application or through a Managed Change Request in the NCTracks Provider Portal.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Orthodontic Transfer Cases
The beneficiary must be receiving orthodontic treatment that was approved by Medicaid, or another state's Children's Health Insurance Program (CHIP) medical assistance program to be considered for continuation of treatment. Orthodontic records will not be reimbursed for transfer cases. Providers are reminded that reimbursement for transfer cases is limited to the remaining number of periodic maintenance visits (D8670) for that beneficiary. At case completion, submit a prior approval request for final orthodontic payment (D8680) for consideration of reimbursement for the deband and retainers.

Refer to **Subsection 7.5 – Orthodontic Case Completion**, for additional information that is required when submitting a case for final orthodontic payment.

7.2.1 In-State Transfer Cases
Prior approval of in-state transfer cases is required. Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code D8670 (periodic orthodontic treatment visit) entered as the requested service and indicate that the request is for in-state transfer in the "Documentation of Medical Necessity" field.
b. A narrative indicating that the case is an "in-state transfer." The narrative must include:
    1. the initial provider's name and address;
    2. the beneficiary's current orthodontic status; and
    3. the treatment plan with the anticipated length of the remaining treatment.

c. If the beneficiary has been banded, submit an American Association of Orthodontists (AAO) Transfer Form.
d. If the beneficiary has not been banded, attach a copy of the Medicaid orthodontic approval from the previous orthodontic provider with the specific detail lines marked "VOID."

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to NCTracks Prior Approval Unit, Orthodontic Review Board.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional instructions for requesting orthodontic prior approval.

7.2.2 Out-of-State Transfer Cases

The beneficiary must have been approved and receiving comprehensive orthodontic treatment under Medicaid or CHIP medical assistance program in their previous state of residence to be considered for continuation of treatment in North Carolina.

Prior approval for out-of-state transfer cases is required. Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code D8670 (periodic orthodontic treatment visit) entered as the requested service and indicate that the request is for out-of-state transfer in the "Documentation of Medical Necessity" field.
b. A narrative indicating that the case is an "out-of-state transfer." The narrative must include:
    1. the initial provider's name and address;
    2. the beneficiary's current orthodontic status; and
    3. the treatment plan with the anticipated length of the remaining treatment.
c. A copy of the American Association of Orthodontists (AAO) Transfer Form or a copy of the orthodontic treatment records from the previous provider.
d. Attach some proof of Medicaid eligibility in the previous state of residence (copy of the Medicaid card from the previous state or records from the previous provider that indicate Medicaid as the payer).
e. Current photographic images (required). Current orthodontic models are helpful but not required.

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to NCTracks Prior Approval Unit, Orthodontic Review Board.

Once approved, it is essential that Medicaid eligibility be confirmed on each date of service. If the beneficiary is not eligible, no payment will be made.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional instructions for requesting orthodontic prior approval.

7.3 Terminated Orthodontic Treatment

Case termination prior to completion of treatment should rarely take place. All efforts should be made to complete the active phase of treatment. If circumstances occur beyond

the control of the dentist (such as beneficiary death or moving out-of-state) that prevents the completion of orthodontic treatment, the provider shall notify the DHHS Utilization Review Contractor.

Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code D8680 (orthodontic retention) entered as the requested service and indicate that the request is for termination of treatment in the "Documentation of Medical Necessity" field.
b. A completed Orthodontic Treatment Termination Request Form.
c. A copy of the beneficiary's treatment notes from the initial visit through the date of termination.
d. Supporting documentation of when and how attempted contacts were made (such as information indicating telephone calls made, messages left with county social worker, relatives, neighbors or friends, letters mailed).
e. Final photographic images are required for consideration of final reimbursement, if deband was rendered.

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to NCTracks Prior Approval Unit, Orthodontic Review Board.

If the beneficiary was only banded, Medicaid may require that a percentage of the banding fee be refunded to the program. This is based on individual case consideration and the circumstances surrounding case termination. In these cases, Medicaid contact the provider to arrange for the refund.

If a beneficiary has been terminated but presents back to the provider for treatment completion, either:

a. Submit a prior approval request to re-establish the remaining maintenance visits (D8670); or
b. Render the deband and retainers (D8680) and submit the prior approval request as described in **Subsection 7.5, Orthodontic Case Completion**.

Refer to **Attachment A – Orthodontic Billing Guide,** for additional information and a copy of the Orthodontic Treatment Termination Request.

7.4 Orthodontic Prior Approval Extension Request (when paid maintenance visits have not exceeded the 23 allowed)

It is anticipated that the orthodontic treatment will be completed within 36 months. When the orthodontic treatment exceeds this three-year approval period and the provider has not received payment for the 23 maintenance visits, the provider shall notify the DHHS Utilization Review Contractor.

Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code D8670 (periodic orthodontic treatment visit) entered as the requested service and indicate that the request is for a prior approval extension in the "Documentation of Medical Necessity" field.
b. A completed Orthodontic Prior Approval Extension Request Form.

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to NCTracks Prior Approval Unit, Orthodontic Review Board.

Claims submitted after the prior approval expiration date will deny with EOB 00023 "SERVICE REQUIRES PRIOR APPROVAL." Until an extension request has been submitted in such cases, Medicaid claims will deny.

Refer to **Attachment A – Orthodontic Billing Guide,** for additional information and a copy of the Orthodontic Prior Approval Extension Request.

7.5 Orthodontic Case Completion

Providers are allowed payment for the banding and 23 maintenance visits. Payment received for banding constitutes about one-third of the maximum allowed for the entire treatment. The balance is paid incrementally with each periodic maintenance visit. The banding and 23 maintenance visits constitute the total reimbursement for comprehensive orthodontic treatment. The provider shall complete any additional maintenance visits necessary to achieve an acceptable treatment outcome without further reimbursement.

In rare instances, it may take fewer than 23 visits to complete treatment. In such cases, a provider may submit a final request for payment of the balance of remaining visits. The request will be considered based on the number of remaining visits and the outcome of the case.

Providers shall notify the DHHS Utilization Review Contractor upon case completion. It is important that Medicaid receive a post-treatment summary so that case records are complete.

Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code D8680 (orthodontic retention) entered as the requested service and indicate that the request is for the final orthodontic review in the "Documentation of Medical Necessity" field.
b. Submit a completed Orthodontic Post-Treatment Summary Form.
c. Final photographic images (required).
d. If fewer than 12 maintenance visits were paid, record review is required to substantiate the final claim payment. Attach a copy of the beneficiary's treatment notes from the initial visit through the delivery of retainers, if applicable. If it is determined that treatment was not "completed" but rather "terminated before treatment objectives were achieved," the final payment may be reduced or not allowed. This is based on individual case consideration and the circumstances surrounding the case.

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to NCTracks Prior Approval Unit, Orthodontic Review Board.

Once the required documentation has been submitted, the request will be manually priced and Medicaid will allow reimbursement based on the number of remaining visits if the case is determined to be a completed case. The post-treatment summary includes the results of the treatment and assessment of the beneficiary's cooperation. The final orthodontic claim will not be paid unless a post-treatment summary is submitted and

procedure code D8680 is approved. After approval has been granted, the provider shall submit the claim for payment to receive the approved reimbursement.

Refer to **Attachment A – Orthodontic Billing Guide**, for additional information and a copy of the Orthodontic Post-Treatment Summary.

7.6 Health Record Documentation

Providers are responsible for maintaining all financial, medical, and other records necessary to fully disclose the nature and extent of services billed to Medicaid. These records must be retained for a period of at least six years from the date of service, unless a longer retention period is required by federal or state law, regulations, or agreements. The provider shall furnish upon request appropriate documentation—including beneficiary records, supporting material, and any information regarding payments claimed by the provider—for review by NC Medicaid, its agents, the Centers for Medicare and Medicaid Services (CMS), the Medicaid Investigations Division of the NC Attorney General's Office, and other entities as required by law. Providers cannot charge for records requested by Medicaid.

The NC State Board of Dental Examiners applicable rule regarding patient records [21 NCAC 16T. 0101(a)] states that a dentist shall maintain complete treatment records on all patients treated for a period of at least ten years. The complete rule is available for review at http://reports.oah.state.nc.us/ncac.asp?folderName=\Title%2021%20-%20Occupational%20Licensing%20Boards%20and%20Commissions\Chapter%2016%20-%20Dental%20Examiners.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

7.7 Transfer of Beneficiary Dental Records

Providers are reminded to provide records of diagnostic quality when transferring dental records to another provider or directly to a beneficiary. Since bitewing radiographic images are allowed once a year and panoramic radiographic images and intraoral complete series of radiographic images are allowed once every five years, it is imperative that the images that are transferred are of diagnostic quality so the provider receiving the images can make a proper diagnosis regarding treatment.

The provider shall comply with 21 NCAC 16T.0102, Transfer of Records Upon Request, which states: *"A dentist shall, upon request by the patient of record, provide all information required by the Health Insurance Portability and Accountability Act (HIPAA) and this Rule, including original or diagnostic copies of radiographs and a legible copy of all treatment records to the patient or to a licensed dentist identified by the patient. The dentist may charge a fee not exceeding the actual cost of duplicating the records. The records shall be provided within 30 days of the request and production shall not be contingent upon current, past or future dental treatment or payment of services."*

Medicaid policy does not prohibit a dentist from charging a record duplication fee to a beneficiary, provided the same fee is charged to private-pay patients. Board rules do not set a maximum level for this duplication fee. When NC Medicaid or the DHHS

Utilization Review Contractor requests records to verify medical necessity or accuracy of billing, providers do not receive compensation.

8.0 Policy Implementation and History

Original Effective Date: July 1, 2002

History:

Date	Section Revised	Change
10/01/2003	All Sections	Implementation of CDT-4 Procedure Codes and style/grammar revisions.
10/01/2004	All Sections	Implementation of the 2002 ADA Dental Claim Form.
09/01/2005	Section 2.3; 5.2; and 5.7	A special provision related to EPSDT was added.
12/01/2005	Section 2.3	The web address for DMA's EPSDT policy instructions was added to this section.
120/1/2006	Section 2.3	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0; 4.0; and 5.0	A note regarding EPSDT was added to these sections.
05/01/2007	Sections 2.0; 3.0; 4.0; and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age.
06/01/2007	Section 5.6	Revised to include the Non-Covered State Medicaid Plan Services Request Form (for recipients under 21 years of age).
06/01/2007	Section 1.0; 5.2; and Attachment A (Orthodontic Billing Guide)	Updated CDT 2006 Copyright disclaimer and revised the Orthodontic Billing Guide to include the 2006 ADA Dental Claim Form.
04/01/2010	1.0; 2.2; 2.3; 5.1; 5.3; 5.7; 5.8; 5.9; 6.0; 7.3; 7.4; 7.5; 7.6; 7.7; 8.0; and Attachment A	Updated CDT 2009/2010 Copyright disclaimer; changed EDS company name to HP throughout the document; removed "pink" regarding the Medicaid for Pregnant Women Medicaid card; removed "blue" regarding the Family Planning Waiver Medicaid card; added statements regarding beneficiaries covered under the Medicare Qualified Beneficiaries program; added statements regarding beneficiaries covered under the Program of All-Inclusive Care for the Elderly (PACE) program; added heading for ADA-Approved Materials; added section on Medical Record Documentation; added section on Compliance; added section on Transfer of Recipient Dental Records; moved the information in Section 8 (Billing Guidelines) to Sections 5 and 7; removed field 58 as a required field on the ADA Dental Claim Form; updated orthodontic forms; made general revisions throughout the policy to improve clarity, grammar, and style; and incorporated standard statements where appropriate.
08/01/2011	1.0; 3.0; 3.1; 3.2; 4.0; 4.1; 4.2; 5.0; 5.1; 5.3, 5.3.1; 5.8; 6.0; 7.0; 7.1; 7.2, 7.2.1; 7.2.2; 7.3; 7.4; 7.5; 7.6; and Attachment A	Updated policy to standard DMA language; changed "functionally handicapping" to "functionally impairing"; updated CDT 2011/2012 copyright disclaimer; clarification of existing criteria and included additional criteria to document covered and non-covered orthodontic treatment; addition of procedure code

		D8070; clarification of existing procedure codes; and clarification of orthodontic transfer cases, terminated cases, and completed cases.
10/01/2011	Throughout	Session Law 2011-145 "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the NC Health Choice Program shall be equivalent to coverage provided for dependents under the North Carolina Medicaid Program." DMA was given the timeframe October 1, 2011 to March 12, 2012 to fully implement the NCHC transition to a Medicaid look-alike program.
03/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Changed fiscal agent references from HP to CSC throughout the document; Updated CDT-2015 procedure code descriptions effective with date of service 1/1/2015; Updated place of service references to HIPAA standards; and updated instructions related to CSC processing.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
7/1/2020	All Sections and Attachments	Updated policy template language; Updated due to CDT 2016, 2017, 2018, 2019 and 2020 additions, deletions and revisions; Included covered orthodontic/orthognathic surgery codes as listed in the Dental Clinical Coverage Policy 4A; Removed optional for photographic images for orthodontic records that must be submitted for prior approval; Added required for photographic images for out-of-state transfer requests, terminated cases that were debanded, and orthodontic case completions; Revised orthodontic criteria based on recommendations from the AAO Committee on Medically Necessary Orthodontic Care; Updated CDT 2020 Copyright disclaimer; Revised the Orthodontic Billing Guide to include the 2019 ADA Dental Claim Form and updated the Orthodontic Treatment Termination Request Form, Orthodontic Prior Approval Extension Request Form, and the Orthodontic Post-Treatment Summary Form.
7/1/2020	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."

12/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 12/15/2023 with an effective date of 4/1/2023.

Attachment A: Orthodontic Billing Guide

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A1: Instructions for Requesting Orthodontic Prior Approval

Once a case has been screened, the orthodontic records obtained, and it is certain the case is **functionally impairing**, the provider shall request prior approval.

Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. Enter the procedure code for the orthodontic treatment (D8070 or D8080) and the procedure codes for the orthodontic records being requested (D0330, D0340 and D0470) with the date rendered as the requested begin date.
b. Attach the panoramic radiographic image (D0330).
c. Attach the 2D cephalometric radiographic image – acquisition, measurement and analysis (D0340).
d. Attach intraoral and facial photographic images (required).
e. Attach a narrative which contains:
    1. the provider's assessment of the beneficiary's motivation, ability to cooperate for orthodontic care, and ability to maintain oral hygiene;
    2. the provider's assessment of the beneficiary's oral condition and the need for treatment;
    3. the provider's assessment of the beneficiary's history of compliance with previous dental care;
    4. the estimated fee for the orthodontic treatment;
    5. the estimated treatment period;
    6. the proposed treatment plan (such as reduce overjet, extract premolars, extract supernumerary teeth, expose impacted teeth, remove cysts, restorations, orthognathic surgery); and
    7. the measures taken to restore decayed teeth and the dates restorations were completed.
f. Print the NC DHHS Prior Approval Health Services Attachment Review Cover Sheet to include in the package of the properly occluded and trimmed dental models with markings that identify the beneficiary's accurate occlusion.

Mail the models with the cover sheet. If submitting the entire case by mail, include a completed ADA Dental Claim Form with all the above listed information. If all the information is not received in the same package, the case will be returned to the provider requesting the additional information. Multiple cases can be sent in the same package. Mail to:

If using: United States Postal Service (USPS)
NCTracks Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

If using: UPS, FedEx, and DHL
NCTracks Prior Approval Unit
ATTN: Orthodontic Review Board
2610 Wycliff Road, Suite 102
Raleigh, NC 27607

When the records are being prepared, be sure that **all** items are clearly labeled with the date taken, the provider's name, and the beneficiary's name for proper handling and return. All radiographic images, photographic images, and models must be of acceptable diagnostic quality or the case will be returned.

Each arch of the model and wax bite (if included) must be wrapped separately in foam, bubble-plastic or a similar padding, and packed in a sturdy corrugated reusable shipping box. Boxes must be sealed with heavy, reinforced paper tape or strapping tape.

Refer to **Subsection 5.1, Prior Approval**, for additional information.

A2: Example of a Completed Orthodontic Prior Approval Request

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☒ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5 -11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in # 4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F ☐ U | 8. Policyholder/Subscriber ID (Assigned by Plan)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

Baker, Frances

13. Date of Birth (MM/DD/CCYY): 05/07/2005 | 14. Gender ☐ M ☒ F ☐ U | 15. Policyholder/Subscriber ID (Assigned by Plan): 598994859H

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F ☐ U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1						D8080			Orthodontic banding	
2	11/01/2019					D0330			Panoramic film	
3	11/01/2019					D0340			Cephalometric film	
4	11/01/2019					D0470			Diagnostic casts	
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 **8 9** 10 11 12 13 14 15 16
32 31 30 29 28 27 26 **25 24 23 22** 21 **20 19 18 17**

34. Diagnosis Code List Qualifier ☐ ☐ (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)
32. Total Fee

35. Remarks
XXXXXXXXXX

AUTHORIZATIONS

36. I have been informed **of the treatment plan and associated fees. I agree to be** responsible for all charges for **dental services and materials not paid by my** dental **benefit** pla , unless prohibited by law, or the **treating dentist or dental practice has a contractual** agreement with my plan prohibiting all or a portion **of such charges. To the extent permitted by law,** I consent to your use and disclosure of my **protected health information to carry out payment activities in** connection with this claim.
X _____
Patient/Guardian **Signature** Date

37. I hereby authorize **and direct payment of the dental** benefits otherwise payable to me, directly to the below named **dentist or dental entity.**
X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Dr. John Hancock
567 Any Street
City, NC 27777-7777

49. NPI: 9999999999 | 50. License Number | 51. SSN or TIN
52. Phone Number: (919) 000-0000 | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☒ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X *John Hancock, DDS* *12/01/2019*
Signed (Treating Dentist) Date

54. NPI: 9999999999 | 55. License Number
56. Address, City, State, Zip Code | 56a. Provider Specialty Code: XXXXXXXXXX
Dr. John Hancock
567 Any Street, City, NC 27777-7777
57. Phone Number: (919) 000-0000 | 58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746
or go online at ADAcatalog.org

A3: Instructions for Filing an Orthodontic Claim

Prior to submitting electronic claims, providers shall enroll with NC Medicaid. The enrollment application is completed online via the NCTracks provider portal. To login to the provider portal you will need a North Carolina Identity (NCID). Reference the "Getting Started" page of the portal located at https://www.nctracks.nc.gov/content/public/providers/getting-started.html for step by step instructions.

Claims are expected to be submitted electronically. Only claims that comply with the exceptions on the NCTracks website at https://www.nctracks.nc.gov/content/public/providers/claims.html may be submitted on paper. Exceptions include time limit overrides, Medicare overrides, and certain adjustment requests.

For those claims that are required to be billed on paper, Medicaid accepts dental claims on the 2019 ADA Dental Claim Form. The following instructions are specific to that form. Paper dental claims ***must*** be completed in black ink only (do not highlight any portion of the claim) to allow the DHHS Utilization Review Contractor to image all dental claim forms electronically.

The following fields ***must be completed as described*** to allow proper processing of dental claims on the 2019 ADA Dental Claim Form.

Field No.	Field Name	Explanation
1	Type of Transaction	Check the appropriate box: • Statement of Actual Services (claim) • Request for Predetermination/Preauthorization (prior approval request) • EPSDT/Title XIX
12	Policyholder/Subscriber Name	Enter the beneficiary's full name (Last, First, Middle Initial) as it appears on the Medicaid card.
13	Date of Birth	Enter the beneficiary's date of birth using eight digits (example: May 7, 2005 – 05/07/2005).
14	Gender	Check the appropriate box: M=male, F=female, or U=unknown.
15	Policyholder/Subscriber ID	Enter the beneficiary's 10-digit identification number listed on the Medicaid card.
23	Patient ID/Account #	Enter the beneficiary's medical record number if used by your office. It will appear on your Remittance and Status Report (RA), if entered.
24	Procedure Date	Enter the date the procedure was completed using eight digits (example: November 1, 2019 – 11/01/2019).
29	Procedure Code	Enter the five digit dental procedure code rendered. **Note:** All procedure codes must begin with the letter "D."
30	Description	Enter the description of the procedure.
31	Fee	**Enter your usual and customary charge for the procedure, *not* the established Medicaid fee.** For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Field No.	Field Name	Explanation

31a	Other Fee(s)	If applicable, enter the amount of payment received from third party insurance plan(s). **Do not** include any payments from Medicare Part B or allowable Medicaid copayments.
32	Total Fee	Enter the total charges for all procedures listed on the claim form. Do not deduct Medicaid copayments or third-party insurance payments listed in field 31a. The fiscal agent will calculate the maximum amount payable by taking into account any copayments or third-party payments.
33	Missing Teeth Information	Cross out (X) missing teeth, slash (/) teeth to be extracted, circle impacted teeth, and show space closure with arrows (←, →).
35	Remarks	Enter the **billing provider's taxonomy**.
38	Place of Treatment	Enter "11" as the place of treatment. Orthodontic services are covered only if delivered in a provider's office.
40	Is Treatment for Orthodontics?	Check Yes.
48	Name, Address, City, State, Zip Code	Enter the name, address, city, state and zip code + 4 code of the dentist or practice that is to receive payment.
49	NPI	Enter the **billing provider's NPI number** of the dentist or practice that is to receive payment. • If payment is to be made to a **group practice**, then enter the **group NPI number**. • If payment is to be made to an **individual dentist**, then enter the **individual dentist NPI number**.
52	Phone Number	Enter the area code and phone number of the billing dentist or practice.
53	Signed (Treating Dentist), Date	Signature of the provider rendering service. The signature certifies that: "Services for which payment is requested are medically necessary and indicated in the best interest of the beneficiary's oral health. The provider's signature on Medicaid documents and claims shall be binding and shall certify that all information is accurate and complete." Enter the signature date using eight digits (example: December 1, 2019 – 12/01/2019).
54	NPI	Enter the **attending provider's NPI number** for the individual dentist rendering service. This number should correspond to the signature in field 53.
56	Address, City, State, Zip Code	Enter the treating dentist's name, address, city, state, and zip code + 4 code.
56a	Provider Specialty Code	Enter the **attending provider's taxonomy**.

If exceptions apply, mail claims to:
NCTracks Claims Unit
PO Box 30968
Raleigh, NC 27622

ADA Dental Claim Forms may be ordered directly from the ADA.
Website: http://ebusiness.ada.org/productcatalog

Address:
American Dental Association
211 E. Chicago Avenue
Chicago, IL 60611-2678

A4: Example of a Completed Claim for Orthodontic Records

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [X] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [ ] EPSDT / Title XIX
2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5 -11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in # 4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F [ ] U
8. Policyholder/Subscriber ID (Assigned by Plan)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code: **Baker, Frances**
13. Date of Birth (MM/DD/CCYY): **05/07/2005**
14. Gender [ ] M [X] F [ ] U
15. Policyholder/Subscriber ID (Assigned by Plan): **598994859H**
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender [ ] M [ ] F [ ] U
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	11/01/2019					D0150			Comp. oral evaluation	75.00
2	11/01/2019					D0330			Panoramic film	125.00
3	11/01/2019					D0340			Cephalometric film	75.00
4	11/01/2019					D0470			Diagnostic casts	75.00
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 **8** **9** 10 11 12 13 14 15 16
32 31 30 29 28 27 26 **25** **24** **23** **22** 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____
31a. Other Fee(s)
32. Total Fee: **350.00**

35. Remarks: **XXXXXXXXXX**

AUTHORIZATIONS

36. I have been informed **of the treatment plan and associated fees. I agree to be** responsible for all charges for **dental services and materials not paid by my** dental **benefit** pla , unless prohibited by law, or the **treating dentist or dental practice has a contractual** agreement with my plan prohibiting all or a portion **of such charges. To the extent permitted by law,** I consent to your use and disclosure of my **protected health information to carry out payment activities in** connection with this claim.
X _____ Patient/Guardian **Signature** Date

37. I hereby authorize **and direct payment of the dental** benefits otherwise payable to me, directly to the below named **dentist or dental entity.**
X _____ Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment: **11** (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [X] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment
43. Replacement of Prosthesis [ ] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code: **Dr. John Hancock, 567 Any Street, City, NC 27777-7777**
49. NPI: **9999999999**
50. License Number
51. SSN or TIN
52. Phone Number: **(919) 000-0000**
52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X *John Hancock, DDS* *12/01/2019* Signed (Treating Dentist) Date
54. NPI: **9999999999**
55. License Number
56. Address, City, State, Zip Code: **Dr. John Hancock, 567 Any Street, City, NC 27777-7777**
56a. Provider Specialty Code: **XXXXXXXXXX**
57. Phone Number: **(919) 000-0000**
58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746 or go online at ADAcatalog.org

A5: Orthodontic Treatment Termination Request

Providers shall submit an Orthodontic Treatment Termination Request when a case is terminated. Case termination prior to completion of treatment should rarely take place. All efforts should be made to complete the active phase of treatment. If circumstances occur beyond control of the dentist (such as beneficiary death or moving out-of-state) that prevent orthodontic treatment completion, the provider shall notify the DHHS Utilization Review Contractor.

Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code D8680 (orthodontic retention) entered as the requested service and indicate that the request is for termination of treatment in the "Documentation of Medical Necessity" field.
b. A completed Orthodontic Treatment Termination Request Form (refer to a copy of this form on the next page). This form is available in NCTracks at https://www.nctracks.nc.gov/content/public/providers/prior-approval.html.
c. A copy of the beneficiary's treatment notes from the initial visit through the date of termination.
d. Supporting documentation of when and how attempted contacts were made (such as information indicating telephone calls made, messages left with county social worker, relatives, neighbors or friends, letters mailed).
e. Final photographic images are required for consideration of final reimbursement, if deband was rendered.

If the beneficiary was only banded, Medicaid may require that a percentage of the banding fee be refunded to the program. This is based on individual case consideration and the circumstances surrounding case termination. In these cases, Medicaid shall contact the provider to make arrangements for the refund.

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to:

NCTracks Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

Refer to **Subsection 7.3, Terminated Orthodontic Treatment**, for additional information.

NORTH CAROLINA MEDICAID PROGRAM
ORTHODONTIC TREATMENT TERMINATION REQUEST

Note: Submit electronically in the NCTracks Prior Approval Portal with procedure code D8680 as the requested service and indicate the request is for termination of treatment. Attach this completed Orthodontic Treatment Termination Request Form and a copy of the recipient's treatment notes from the initial visit through the date of termination along with supporting documentation of when and how attempted contacts were made to the recipient. Attach final photographic images if deband was rendered.

Date: _____

Recipient name: _____ Medicaid ID #: _____

Date of termination: _____
Date of debanding: _____
Months in treatment: _____
Estimated months needed to complete treatment: _____

Number of paid maintenance visits: _____
Date retainers delivered: _____
Retainers delivered:
Upper: ☐ Yes ☐ No
Lower: ☐ Yes ☐ No

Reason for termination:

- ☐ recipient moved out of state
- ☐ recipient joined the military
- ☐ recipient non-compliance
- ☐ recipient removed appliances
- ☐ parent/guardian request removal
- ☐ recipient death
- ☐ recipient transferred to another provider (specify)_____
- ☐ other (specify)_____

Comments: _____

_____

_____

If the recipient was only banded, Medicaid or NCHC may require that a percentage of the banding fee be refunded to the program. This is based on individual case consideration and the circumstances surrounding case termination. In these cases, Medicaid or NCHC will contact the provider to make arrangements for the refund.

Billing provider NPI:	
Billing provider name:	
Service location address:	
Service location phone:	

** If submitting by mail, submit a completed ADA Dental Claim Form with procedure code D8680 along with the required documentation as stated above. Mail to:*

NCTracks Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

DHB-0007 (Revised 2019)

A6: Orthodontic Prior Approval Extension Request

It is anticipated that the orthodontic treatment will be completed within 36 months. Providers shall submit an Orthodontic Prior Approval Extension Request whenever treatment extends beyond the original 36-month approval period. Claims submitted after the prior approval expiration date will deny with EOB 00023 "SERVICE REQUIRES PRIOR APPROVAL." Until an extension request has been submitted in such cases, Medicaid claims will deny.

Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code D8670 (periodic orthodontic treatment visit) entered as the requested service and indicate that the request is for a prior approval extension in the "Documentation of Medical Necessity" field.
b. A completed Orthodontic Prior Approval Extension Request Form (refer to a copy of this form on the next page). This form is available in NCTracks at https://www.nctracks.nc.gov/content/public/providers/prior-approval.html.

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to:

NCTracks Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

Refer to **Subsection 7.4, Orthodontic Prior Approval Extension Request,** for additional information.

NORTH CAROLINA MEDICAID PROGRAM
ORTHODONTIC PRIOR APPROVAL EXTENTION REQUEST

Note: When the orthodontic treatment exceeds the three-year approval period and the provider has not received payment for the 23 maintenance visits, submit electronically by uploading this request to the NCTracks Prior Approval Portal with procedure code D8670 as the requested service and indicate that the request is for a prior approval extension.

Date: _____

Recipient name: _____ Medicaid ID#: _____

Months in treatment: _____ Number of paid maintenance visits: _____

Estimated months needed to complete treatment: _____

Reason for extension: _____

_____

_____

_____

Claims submitted after the prior approval expiration date will deny with EOB 00023 "SERVICE REQUIRES PRIOR APPROVAL." Until an extension request has been submitted in such cases, Medicaid or NCHC claims will deny.

Billing provider NPI:	
Billing provider name:	
Service location address:	
Service location phone:	

** If submitting by mail, submit a completed ADA Dental Claim Form with procedure code D8670 along with this Orthodontic Prior Approval Extension Request. Mail to:*

NCTracks Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

DHB-0006 (Revised 2019)

A7: Orthodontic Post-Treatment Summary

Providers shall notify the DHHS Utilization Review Contractor upon case completion. It is important that Medicaid receive a post-treatment summary so that case records are complete.

Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the following information:

a. CDT Code D8680 (orthodontic retention) entered as the requested service and indicate that the request is for the final orthodontic review in the "Documentation of Medical Necessity" field.
b. Submit a completed Orthodontic Post-Treatment Summary Form (refer to a copy of this form on the next page). This form is available in NCTracks at https://www.nctracks.nc.gov/content/public/providers/prior-approval.html.
c. Final photographic images (required).
d. If fewer than 12 maintenance visits were paid, record review is required to substantiate the final claim payment. Attach a copy of the beneficiary's treatment notes from the initial visit through the delivery of retainers, if applicable. If it is determined that treatment was not "completed" but rather "terminated before treatment objectives were achieved," the final payment may be reduced or not allowed. This is based on individual case consideration and the circumstances surrounding the case.

If submitting by mail, submit a completed ADA Dental Claim Form with the above listed information. Mail to:

NCTracks Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

Refer to **Subsection 7.5, Orthodontic Case Completion**, for additional information.

NORTH CAROLINA MEDICAID PROGRAM
ORTHODONTIC POST-TREATMENT SUMMARY

Note: Submit electronically by uploading the request to the NCTracks Prior Approval Portal with the procedure code D8680 as the requested service and indicate that the request is for the final orthodontic review and payment, if applicable. Attach this completed Orthodontic Post-Treatment Summary Form and final photographic images. If fewer than 12 maintenance visits were paid, attach a copy of the recipient's complete treatment notes from the initial visit through the delivery of retainers.

Date: _____

Recipient name: _____ Medicaid ID: _____

Date of debanding: _____
Number of paid maintenance visits: _____
Date retainers delivered: _____

Retainers delivered:
Upper: ☐ Yes ☐ No
Lower: ☐ Yes ☐ No

Results obtained:
- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Assessment of recipient cooperation:
- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Comments: _____
_____
_____

If it is determined that treatment was not "complete" but rather "terminated before treatment objectives were achieved," the final payment may be reduced or not allowed. This is based on individual case consideration and the circumstances surrounding the case.

Billing provider NPI:	
Billing provider name:	
Service location address:	
Service location phone:	

** If submitting by mail, submit a completed ADA Dental Claim Form with procedure code D8680 along with the required documentation as stated above. Mail to:*

NCTracks Prior Approval Unit
ATTN: Orthodontic Review Board
PO Box 31188
Raleigh, NC 27622

DHB-0005 (Revised 2019)