ORTHODONTIC COVERAGE FOR CHILDREN

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirement.

Orthodontic services may be provided by Orthodontists and Dentists.

ELIGIBLE RECIPIENTS

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

New Treatment
The recipient must be under age 21 and eligible for South Dakota Medicaid at the beginning of orthodontic treatment.

Continuation of Treatment Started before Recipient was Medicaid Eligible
When an individual who is already in active orthodontic treatment becomes eligible for Medicaid the orthodontic case may be submitted to South Dakota Medicaid for consideration of coverage. Coverage will depend on a qualifying score based on a review of the records at the time the recipient started orthodontic care. The original records must be submitted to the Dental Vendor for evaluation. The recipient must be under age 21. If the recipient's current provider is not the provider who initiated the original care, it is the patient's responsibility to obtain the records from the original provider. If approved for benefits, the allowable fee will be prorated based on the treatment start date and the treatment remaining.

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

ORTHODONTIC TREATMENT PRIOR AUTHORIZATION

The recipient must meet all of the following criteria to be approved for orthodontic treatment:

1. Recipient is under age 21 at the commencement of treatment.

2. Completion of the Pre-Orthodontic Certification Form signed by the recipient's general dentist attesting:
    - Recipient is up to date with preventative care;
    - Recipient exhibits good oral hygiene practices at home; and
    - Recipient is up to date with restorative work.

3. The treatment is medically necessary as determined by a score of 30 or higher on the Handicapping Labio-Lingual Deviations Form (HLD Index). The orthodontic provider must submit a completed copy of the HLD Index and the accompanying documentation for verification of score by dental consultants:
    - Full mouth panoramic or cephalometric films;
    - Facial and intraoral photos; and
    - Detailed treatment plan along with diagnosis.

4. Parent/legal guardian of the recipient completes an Orthodontic Education Session with a Medicaid Dental Care Coordinator.

5. Parent/legal guardian of the recipient sign and return statement of orthodontic service agreement document summarizing the patient responsibilities discussed in the Orthodontic Education Session.

The Dental Vendor will send notification authorizing the orthodontic provider to begin treatment only after all above criteria have been met. No orthodontic treatment payments will be made for patient who has not been approved for treatment.

COVERED SERVICES AND LIMITS

Covered orthodontic treatment is limited to those procedure codes contained in this manual and listed on the South Dakota Medicaid Children Services Dental Fee Schedule. The orthodontic provider must submit a pre-determination request for all orthodontic services prior to beginning treatment.

Orthodontic treatment must be medically necessary to correct a handicapping malocclusion.
Medically necessary orthodontic treatment is treatment necessary to correct a condition that constitutes a handicapping malocclusion which scores 30 or higher on the Handicapping Labio-Lingual Deviations Form (HLD Index).

Orthodontic treatment includes treatment of transitional, adolescent, or adult dentition, as well as treatment with orthognathic surgery. Treatment may incorporate several phases with specific objectives at various stages of dento-facial development.

When limited and comprehensive orthodontic treatment scores on the HLD Index are less than 11, the orthodontic records will not be benefited. The recipient may be billed for the cost of the services provided. Providers should inform the recipient in advance that they may be billed if their score is less than 11.

Limited and Comprehensive Orthodontic Services
Limited orthodontic treatment does not involve the entire dentition or the full scope of the orthodontic problem and is not part of the comprehensive treatment plan. Treatment may include but is not limited to mitigating an aspect of a greater malocclusion such as crossbite, overjet, overbite, arch length, or anterior alignment. Comprehensive orthodontic treatment includes the entire mouth that leads to improvement of the patient's craniofacial dysfunction or dentofacial deformity.

The Dental Vendor must authorize limited and comprehensive orthodontic treatment plans before any treatment is initiated. Authorization is based on documentation submitted to the Dental Vendor by the provider. The documentation must include:

- American Dental Association preauthorization claim form;
- Full mouth panoramic or cephalometric films;
- Facial and intraoral photos;
- Detailed treatment plan along with diagnosis;
- Pre-Orthodontic certification form; and
- Handicapping Labio-Lingual Deviations form (HLD Index).

Approval of a limited treatment plan does not automatically guarantee approval of a comprehensive treatment plan.

Approval of orthodontic treatment with orthognathic surgery includes coverage for the full orthodontic treatment plan pre- and post-surgery. Coverage does not guarantee medical coverage of the surgical component.

Retainer Replacement, Repair, and Re-cements or Re-bonds
Replacements, repairs, re-cements, and re-bonds are a one-time benefit only. Replacement, repair, and re-cement or re-bond benefits are only available to recipients if South Dakota Medicaid covered the limited or comprehensive treatment plan.

In State Transfer of Orthodontic Care in Progress
If a recipient who has been previously approved for orthodontic benefits moves, and the orthodontic treatment will be continued by another provider, the new provider should submit a claim with his/her diagnostic workup and treatment plan to the dental vendor. The claim must include the time and fee needed to complete the treatment. Upon approval a new voucher will be issued to the provider indicating the prorated payment for the completion of treatment.

The prorated payment will be based on the original authorized reimbursement amount divided by the total treatment months (sum of months from previous provider and new provider's treatment plans) and then multiplied by the remaining months of treatment, not to exceed 100 percent of the total allowable reimbursement.

Out of State Transfer of Orthodontic Care in Progress
If a recipient who has already started orthodontic treatment in a different state moves, and the orthodontic treatment will be continued by a South Dakota Medicaid provider, the new provider should submit a claim with his/her diagnostic workup and treatment plan to the dental vendor. The claim must include:

- ADA preauthorization claim form with the fee needed to complete treatment;
- Copy of the previous providers orthodontic records prior to the start of treatment;
- AOA transfer form showing any amount already paid on the orthodontic case;
- Pre-Orthodontic certification form; and
- Handicapping Labio-Lingual Deviations form (HLD Index).

The recipient must meet all of the orthodontic treatment prior authorization criteria for final approval of orthodontic treatment coverage. Upon approval a new voucher will be issued to the provider indicating the prorated payment for the completion of treatment. The prorated payment will be based on the original authorized reimbursement amount divided by the total treatment months (sum of months from previous provider and new provider's treatment plans) and then multiplied by the remaining months of treatment.

If the recipient does not qualify for orthodontic benefits under South Dakota Medicaid and the family wants to consider having all appliances removed, a claim with the applicable fee and clinical notes is required to be submitted.

NON-COVERED SERVICES

Non-covered services include:

- Orthodontic treatment for individuals over age 21;
- Treatment not authorized by South Dakota Medicaid's dental vendor;
- Modifications to treatment plans or new treatment plans when the recipient is no longer Medicaid eligible.

DOCUMENTATION REQUIREMENTS

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Radiograph images must be interpreted and included in the recipient's medical record. Documentation is needed, even if the findings indicate no pathosis, to support treatment planning decisions. Please refer to the Documentation and Record Keeping manual for additional requirements.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Reimbursement for orthodontic services is made using a standard 24-month treatment plan timeline.

Payments are made in the following increments based on the recipient's completion of each approved treatment phase and date appliances are placed:

- First payment is one-half of the total allowance, issued at the time of placement of orthodontic appliances.
- Second payment is one-quarter of the total allowance, issued after twelve months at treatment midpoint. The orthodontic provider must submit documentation supporting that the individual is an active treatment. The Dental Vendor will verify the patient is in active treatment prior to issuing the payment. The orthodontic provider's failure to submit supporting documentation at treatment midpoint may result in a forfeiture of the second payment due to timely filing requirements.
- Final payment is one-quarter of the total allowance, issued at the completion of treatment. The orthodontic provider must submit documentation that full treatment has been rendered, including final treatment records. The orthodontic provider's failure to submit supporting documentation at the point of treatment completion may result in a forfeiture of the final payment due to timely filing requirements.

If the patient does not complete the entire orthodontic treatment with the authorized provider, payment is subject to the refund based on the above formula.

South Dakota Medicaid covers the repair or replacement of one orthodontic appliance. Any additional repairs or replacements are the recipient's responsibility.

Payment for Recipients who Lose Medicaid Eligibility During Treatment
South Dakota Medicaid covers the second and final payment of an approved treatment plan provided all payment criteria is met if the recipient loses Medicaid eligibility during the approved treatment plan period. Modifications to the treatment plan, extensions of the treatment plan, and ancillary procedures performed by an oral surgeon or other provider are not covered when a recipient loses Medicaid eligibility.

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort.

Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

DEFINITIONS

1. "HLD," Handicapping Labio-Lingual Deviations Form – a qualitative, objective method for measuring malocclusion.

2. Orthodontic education session – a required phone call between the Medicaid Care Coordinator and the patient's parent or guardian discussing the patient's responsibilities related to orthodontic treatment and the potential barriers to successfully completing treatment.

3. Statement of orthodontic services agreement – statement signed by the patient's parent or guardian that they understand their responsibilities related to the orthodontic treatment.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **A patient with Medicaid coverage contacted our office for an orthodontic assessment but does not have a general dentist. What should we do?**

   Explain to the patient that it is required to have the Pre-Orthodontic Certification Form signed by a general dentist prior to completing an orthodontic assessment. Your office can schedule the patient for an assessment, but the patient must have the form signed prior to the appointment. Recipients without a dental home may be referred to the Delta Dental of South Dakota contact center at 1-877-841-1478 for assistance in locating a dental home.

2. **Who can help find a general dentist or dental home for a recipient?**

   Medicaid recipients can be referred to the Delta Dental of South Dakota contact center at 1-877-841-1478 for assistance in locating a dental home.

3. **One of my patients has missed appointments and now I am unable to reach him/her. Does Medicaid have any resources that can help contact the patient?**

   The Medicaid Dental Care Coordination team assists dental providers with "at risk" individuals. Providers may use the At-Risk Referral Form and Instructions to refer Medicaid recipients to the Medicaid Dental Care Coordination team for dental care coordination services. The At-Risk Referral Form is submitted to the Dental Care Coordination team by email.

To initiate the process. e-mail sdmedicaid@deltadentalsd.com to receive the At-Risk Referral form with instructions. More information can be found in the South Dakota Medicaid Dental Care Coordination provider manual.

4. **A patient with Medicaid coverage says they want an appointment without meeting the criteria and they will pay in cash. Can my office schedule them as a private pay patient?**

   If your office accepts Medicaid as a payment source and the patient has Medicaid coverage, the treatment plan must be submitted to Medicaid for review before entering into a private pay agreement. If the recipient meets the criteria for coverage, the office must bill Medicaid for the treatment.