Effective for dates of service on or after March 1, 2012, benefit criteria for Texas Health Steps (THSteps) orthodontic dental services will change for Texas Medicaid.

The following policy will apply to those clients still served, after March 1, 2012, by THSteps. TMHP will authorize and process orthodontic services claims only for clients who are residents of an intermediate care facility for persons with intellectual disabilities (ICF-MR).

CHIP and most Medicaid clients will transition as of March 1, 2012, to dental managed care plans. Dental managed care plans will be responsible for prior authorizing, processing, and reimbursing any orthodontic services rendered to CHIP and most Medicaid managed care client. Providers should check with the Managed Care Organization (MCO) administering a client’s services for information about that plan.

Claims for orthodontic services that were initially authorized by TMHP but later transitioned to a managed care dental plan will be processed and reimbursed by the dental plan. Providers should check client eligibility to identify the managed care dental plan in which the client is enrolled.

Effective for dates of service on or after March 1, 2012, the following changes will be implemented.

**Note:** *No guidelines or reimbursement changes will occur to comprehensive orthodontic services that have prior authorization approval before March 1, 2012.*

- The [Texas Health Steps (THSteps) Dental Mandatory Prior Authorization Request Form](#) will be revised.
- Replacement brackets (procedure code D8690) will be limited to a combined total amount of $100.00, same provider.
- Monthly adjustments (procedure code D8670) will be limited to up to 10 visits that are prior authorized with procedure code D8210 or D8220.
- Texas Medicaid will no longer reimburse for any diagnostic workups for treatment plans that are not approved. Dentists should determine whether the client’s condition meets orthodontic coverage criteria before performing a diagnostic workup.

**Provider Requirements**

Providers must follow all provider requirements in order to be reimbursed for orthodontic dental services.

All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including the standards for documentation and record maintenance that are stated in the TSBDE Rules 108.7 Minimum Standards of Care, General and 108.8 Records of the Dentist.

Dentists (D.D.S., D.M.D.) who want to provide orthodontic services must be enrolled as a dentist or orthodontist provider for THSteps and must have at least one of the qualifications listed below.
• THSteps dental providers (provider type 48) may perform and be reimbursed for orthodontic services if they have attested to at least one of the following requirements:
  o Completion of a dental pediatric specialty residency
  o Completion of a minimum of 200 hours of continuing education in orthodontics within the last 10 years (8 hours can be online or self instruction). Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services; however, documentation must be produced by the dentist during retrospective review.

• Orthodontist providers (provider type 90) are eligible to provide orthodontic services. In order to comply with the TSBDE rules and regulations, this designation can only be associated with dentists who are board-eligible or board-certified by an American Dental Association (ADA) recognized orthodontic specialty board.

**Comprehensive Orthodontic Services**

Comprehensive orthodontic services are a benefit for THSteps clients who are 13 years of age and older and have either:

• Permanent dentition and a severe handicapping malocclusion
• One of the following special medical conditions:
  o Cleft palate
  o Head-trauma injury involving the oral cavity
  o Skeletal anomalies involving the oral cavity

A severe handicapping malocclusion is defined by Texas Medicaid as dysfunctional masticatory (chewing) capacity as a result of the existing relationship between the maxillary (upper) and mandibular (lower) dental arches or teeth that without correction will result in damage to the temporomandibular joint(s) (TMJ) or other supporting oral structures (e.g., bone, tissues, intra- or extra-oral muscles, etc.)

Exception to the age restriction may be considered for clients who are 12 years of age and younger if medical necessity has been verified by the dental director for one of the following:

• Interceptive orthodontic treatment services
• Crossbite therapy
• Limited orthodontic treatment and minor treatment to control harmful habits
• Special medical conditions

Dental services that are not covered by THSteps Dental Services but are medically necessary and allowable may be a benefit under the Comprehensive Care Program (CCP) according to federal Medicaid guidelines and the Texas Administrative Code (TAC).

As required by the TAC, if the client is 14 years of age or younger and services are not provided by an exempt entity, THSteps dental providers shall require the recipient to be
accompanied to THSteps dental appointments by a parent, guardian, or other adult who is authorized by the parent or guardian.

Exempt entities (school health clinics, Head Start program, or childcare facilities) that provide services must as a condition of reimbursement:

- Obtain written, unrevoked consent for the services from the client’s parent or legal guardian within a one-year period before the date of service.
- Encourage parental involvement in and management of the health care of the clients who receive services from the clinic, program, or facility.

The following definitions of dentition established by the ADA’s Current Dental Terminology (CDT) manual are recognized by Texas Medicaid:

- **Primary Dentition**: Teeth developed and erupted first in order of time.
- **Transitional Dentition**: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
- **Adolescent Dentition**: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.
- **Adult Dentition**: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

The American Association of Orthodontists classification of occlusion or malocclusion is as follows:

- **Class I**: A Class I occlusion exists with the teeth in a normal relationship when the mesial buccal cusp of the maxillary first permanent molar coincides with the buccal groove of the mandibular first molar.

- **Class II**: A Class II malocclusion occurs when the mandibular teeth are distal or behind the normal relationship with the maxillary teeth. This can be due to a deficiency of the lower jaw or an excess of the upper jaw and, therefore, presents two types:
  - Division I is when the mandibular arch is behind the upper jaw with a consequential protrusion of the upper front teeth.
  - Division II exists when the mandibular teeth are behind the upper teeth, with a retrusion of the maxillary front teeth. Both of these malocclusions have a tendency toward a deep bite because of the uncontrolled migration of the lower front teeth upwards.

- **Class III**: A Class III malocclusion occurs when the lower dental arch is in front of (mesial to) the upper dental arch. People with this type of occlusion usually have a strong or protrusive chin, which can be due to either horizontal mandibular excess or horizontal maxillary deficiency. Commonly referred to as an underbite.

Comprehensive orthodontic services must be provided by a board-eligible or board-certified orthodontist.

**Note**: Exceptions to a board-eligible or board-certified orthodontist may be considered for clients in a rural or frontier area or where access to care is an issue.
The diagnostic workup is considered part of the pre-orthodontic treatment visit (procedure code D8660). The following procedure codes are used to submit claims for the diagnostic workup:

<table>
<thead>
<tr>
<th>Diagnostic Workup Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0330</td>
</tr>
<tr>
<td>D0340</td>
</tr>
<tr>
<td>D0350</td>
</tr>
<tr>
<td>D0470</td>
</tr>
</tbody>
</table>

Comprehensive orthodontic services include all of the following:
- Diagnostic workups
- Banding
- Initial brackets
- Replacement brackets
- Monthly visits
- Initial retainers
- Special orthodontic treatment appliance(s)

The following procedure codes are used to submit claims for orthodontic services:

<table>
<thead>
<tr>
<th>Orthodontic Services Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8080</td>
</tr>
<tr>
<td>D8660</td>
</tr>
<tr>
<td>D8670</td>
</tr>
<tr>
<td>D8690</td>
</tr>
</tbody>
</table>

Full banding is allowed on permanent dentition only, and treatment should be accomplished in one stage and is limited to once per lifetime.

**Exception:** Cases of mixed dentition may be considered when the treatment plan includes extractions of remaining primary teeth or in the case of cleft palate.

**Crossbite Therapy**

Crossbites (anterior and posterior) are defined by the American Academy of Pediatric Dentistry (AAPD) as malocclusions involving one or more teeth in which the maxillary teeth occlude lingually with the mandibular antagonistic (opposing) teeth. A crossbite can be of a dental or skeletal origin or a combination of both.

The intent of crossbite therapy is to prevent the need for comprehensive orthodontic treatment. This treatment may lessen the severity or future effects of a malformation, eliminate its cause, or may include localized tooth movement.

Crossbite therapy (limited orthodontics) is allowed for primary or transitional dentition. Crossbite therapy will not be considered for transitional dentition when there is a need for full banding of the adult teeth.

Crossbite therapy may be considered when submitted with procedure code D8050 or D8060. Clients with special medical conditions may be considered for interceptive orthodontic services of the primary dentition if the services are medically necessary and submitted with procedure code D8050.

Crossbite therapy is an inclusive charge for treating the crossbite to completion. Adjustments, maintenance, diagnostic models, and diagnostic workup procedures are not reimbursed separately.
**Minor Treatment to Control Harmful Habits**

Special orthodontic appliances are a covered benefit for minor treatment to control harmful habits.

Procedure codes D8210, D8220, and D8670 are used to submit claims for orthodontic appliances for minor treatment to control harmful habits.

Monthly adjustments (procedure code D8670) are limited up to 10 visits.

Claims for panoramic films (procedure code D0330), cephalometric films (procedure code D0340), oral/facial photographic images (procedure code D0350) and diagnostic models (procedure code D0470) will be denied when they are submitted with procedure code D8210 or D8220.

Each orthodontic appliance (procedure code D8210 and D8220) are limited to once per arch, per lifetime.

**Premature Termination of Comprehensive Orthodontic Treatment**

Procedure code D8680 is used to submit claims for premature termination of comprehensive orthodontic treatment.

Removal of the appliance (procedure code D8680) will be denied if the claim is submitted by any provider on the same date of service as orthodontic treatment (procedure codes D8050, D8060, and D8080).

If premature removal of the appliances is requested before completion of treatment, future orthodontic services may not be considered. The provider must document why the premature removal was necessary.

**Other Orthodontic Services**

Replacement brackets (procedure code D8690) are a benefit when the client transfers from one provider to another or when trauma is involved.

Providers are responsible for any replacement brackets that are required as part of the comprehensive orthodontic treatment. Additional reimbursement for replacement brackets (procedure code D8690) is limited to a combined total amount of $100.00, same provider.

Rebonding, recementing, or repair of fixed orthodontic appliances (procedure code D8693) may be reimbursed once per lifetime per orthodontic appliance.

Only one retainer per arch per lifetime (procedure code D8680) is allowed; however, each retainer may be replaced with prior authorization once per lifetime due to loss or breakage. Retainer adjustments are not reimbursed separately.

Appliances required as part of the cleft palate treatment plan may be reimbursed separately.

Special orthodontic appliances may be used with full banding and crossbite therapy when approved by the TMHP Dental Director or Associate Dental Director.
Authorization Requirements

Prior authorization is required for all orthodontic services except for rebonding, recementing, or repair, as required, of fixed retainers (procedure code D8693). Providers must maintain documentation of medical necessity in the client’s dental record for rebonding or recementing of fixed retainers.

Orthodontic services do not include any related services outside those listed in this article (e.g., extractions or surgeries); however, all services must be included in the orthodontic treatment plan.

Approved orthodontic treatment plans must be initiated before clients lose Medicaid eligibility or reach 21 years of age, and all active orthodontic treatments must be completed within 36 months of the authorization date. Services cannot be added or approved after eligibility has expired.

After receiving prior authorization, providers must advise clients that they are able to receive the approved orthodontic service (including monthly orthodontic adjustment visits and retainers) even if they lose their Medicaid eligibility or reach 21 years of age. **Note:** If a client reaches 21 years of age or loses Medicaid eligibility before the authorized orthodontic services are completed, reimbursement is provided to complete the orthodontic treatment plan that was authorized and initiated while the client was 20 years of age or younger and eligible for Texas Medicaid as long as the orthodontic treatment plan is completed within the appropriate time frames.

Any non-orthodontic service that is included as part of the treatment plan (extractions or surgeries) must be completed before the client loses eligibility or reaches 21 years of age in order to be reimbursed through Texas Medicaid. Services cannot be added or approved after Texas Medicaid eligibility has expired.

All requests must be reviewed by the TMHP Dental Director or other state dental contractor’s board-eligible or board-certified orthodontist employee or consultant who is licensed in Texas.

To avoid unnecessary denials, providers must submit correct and complete information, including documentation for medical necessity for the service(s) requested. Providers must maintain documentation of medical necessity in the client’s medical record. Requesting providers may be asked for additional information to clarify or complete a request.

A completed Texas Health Steps (THSteps) Dental Mandatory Prior Authorization Request Form must be signed and dated by the performing dental provider. All signatures and dates must be current, unaltered, original, and handwritten. Computerized or stamped signatures and dates will not be accepted. The completed authorization form must include the procedure codes for all services requested along with a written statement of medical necessity for the proposed orthodontic treatment.

All prior authorization requests for orthodontic services must be accompanied by an attestation from the requesting provider that the provider is either a pediatric dentist or orthodontist.

General dentists who are requesting prior authorization for orthodontic services must attest and maintain documentation of a minimum of 200 hours of continuing dental education specifically in orthodontics within the last 10 years; 8 hours can be online or self instruction.
Proof of the completion of continuing education hours is not required to be submitted with a request for prior authorization of orthodontic services. However, documentation must be produced by the dentist during retrospective review. All attestations are subject to compliance review and orthodontic services may be subject to recoupment.

**Initial Orthodontic Services Request**

The prior authorization form must include all of the procedures that are required to complete the requested treatment including, but not limited to, the following:

- Diagnostic workup
- Medically necessary extractions (Tooth ID must be included)
- Orthognathic surgery
- Upper and lower appliance
- Monthly adjustments
- Special orthodontic treatment appliances
- Placement of banding and brackets
- Replacement of brackets
- Removal of the brackets and arch wires
- Other special orthodontic appliances
- Fabrication of special orthodontic appliances
- Delivery of orthodontic retainers
- Appliance removal (if indicated)

A completed and scored Handicapping Labio-Lingual Deviations (HLD) Index with a diagnosis of Angle class (a minimum of 26 points are required for approval of non-cleft palate cases). If attaining a qualifying score of 26 points is uncertain, a brief narrative should be provided.

**Note:** A score of a minimum 26 points on the HLD index does not indicate an automatic approval for comprehensive orthodontics. Approval will be based on the diagnostic workup supporting the HLD index. Documentation provided must be reviewed by a qualified board eligible or board certified orthodontist.

When requesting prior authorization, providers must include diagnostic models, radiographs (X-rays), cephalometric X-ray with tracings, photographs, and other supporting documentation with the appropriate prior authorization request form.

All required documents must be submitted together in one package per prior authorization request. Prior authorization requests that are not submitted in one package per request will be considered incomplete.

**Note:** All documentation submitted with an incomplete request will be sent back to the provider with a letter that indicates the prior authorization request was incomplete. Providers may resubmit prior authorization requests with all the required documentation.
Diagnostic Tools

Prior authorization requests must include the date of service the diagnostic tools were obtained (the date of service the dental records were produced). All diagnostic tools must be properly labeled and protected when shipped by the provider. If any diagnostic tool is damaged during shipment, the provider may be required to reproduce the documentation for consideration of the case for prior authorization.

**Note:** If medical necessity cannot be determined from the diagnostic tools that are submitted with the request, the prior authorization request may be denied.

**Note:** TMHP will be responsible for retaining an image of each diagnostic tool that is submitted for every complete orthodontic prior authorization request.

Copies of diagnostic models, X-rays, and any other paper diagnostic tools will be accepted and are preferred. Copies will not be returned, but providers will be required to maintain the dental records for retrospective review. Originals will be returned to the submitting provider only when the document is clearly marked "original."

Diagnostic models in the form of plaster casts are preferred; however, providers may choose the positions in which the casts are made. E-models must be in the centric occlusion position.

Radiographs that are submitted must include, but are not limited to, the following:

- Panoramic or a full mouth series
- Cephalometric with tracings

Photographic images must be submitted with the request and must be in a 1:1 ratio format (actual size), including, but not limited to, the following:

- Full face, smiling
- Left and right profiles
- Full maxillary arch (open mouth view)
- Full mandibular arch (open mouth view)
- Right side occluded in centric occlusion
- Left side occluded in centric occlusion
- Anterior occluded in centric occlusion

X-rays must be of diagnostic quality and do not have to be submitted on photographic quality paper.

Submitting providers must attest that radiographs, photographs, and other documentation are unaltered.

**Handicapping Labio-Lingual Deviation (HLD) Index**

The orthodontic provider must complete and sign the HLD Index (Angle classification). The HLD index requires the use of a HLD score sheet and a Boley gauge for measuring.

Scoring should be conservative. The client must be considered severe handicapping malocclusion with dysfunctional masticatory (chewing) capacity as a result of the existing relationship between the maxillary (upper) and mandibular (lower) dental arches and/or
teeth that, without correction, will result in damage to the temporomandibular joint(s) (TMJ) and/or other supporting oral structures (e.g., bone, tissues, intra and/or extra oral muscles, etc.) and have a minimum of 26 points on the HLD index to be considered for any orthodontic care other than crossbite correction. “Halfmouth” treatment cannot be approved.

With the client or models in the centric position, the HLD index is to be scored as follows. Record all measurements rounded-off to the nearest millimeter (mm). Enter a score of “0” if the condition is absent.

- **Cleft Palate**: A cleft palate request for mixed dentition will be considered only if narrative justification supports treatment before the client reaches full dentition.

  *Note: Intermittent treatment requests may exceed the allowable 26 reimbursable treatment visits.*

- **Severe Traumatic Deviations**: Refers to facial accidents only. Points cannot be awarded for congenital deformity. It does not include traumatic occlusion for crossbites.

- **Overjet in Millimeters**: Score the client exactly as measured. The measurement should be recorded from the most protrusive incisor, then subtract 2 mm (a 2 mm deviation is considered the norm) and enter the difference as the score.

- **Overbite in Millimeters**: Score the client exactly as measured. The measurement should be recorded from the labio-incisal edge of the overlapped anterior tooth or teeth to the point of maximum coverage, then subtract 3 mm (a 3 mm deviation is considered the norm) and enter the difference as the score.

- **Mandibular Protrusion in Millimeters**: Score the client exactly as measured. The measurement should be recorded from the “line of occlusion” of the permanent teeth, not from the ectopically erupted teeth in the anterior segment. Caution is advised in undertaking treatment of open bites in older teenagers because of the frequency of relapse.

- **Ectopic Eruption**: An unusual pattern of eruption, such as high labial cuspids or teeth that have erupted in a position that is grossly out of the long axis of the alveolar ridge. Ectopic eruption does not include teeth that are rotated or teeth that are leaning or slanted especially when the enamel-gingival junction is within the long axis of the alveolar ridge.

  *Note: Providers should record the more serious condition. Providers must not include (score) teeth from an arch if that arch is to be counted in the following category of “Anterior Crowding.” For each arch, either the ectopic eruption or the anterior crowding may be scored, but not both.*

- **Anterior Crowding**: Arch length insufficiency must exceed 3.5 mm to be considered as crowding in either arch. Mild rotation that may react favorably to stripping or moderate expansion procedures are not to be scored as “crowded.”

- **Excessive Anterior Spacing in Millimeters**: The score for this category must be the total of the anterior spaces in millimeters.
Authorization Extensions

Extensions on allowed time frames may be considered no sooner than 60 days before the authorization expires. Extra monthly adjustments (procedure code D8670) will not be prior authorized, but the time frame may be considered for extension not to exceed 36 months of actual treatment. Providers must submit the following:

- Diagnostic workup.
  
  **Note:** Photographs may be substituted for models.

- The reason the treatment was not completed in the original time frame.

- An explanation of the treatment plan status.

Crossbite Therapy

Requests for crossbite therapy (procedure codes D8050 or D8060) require the submission of diagnostic models to receive authorization. An HLD score sheet is not required for crossbite therapy.

Providers that submit requests for crossbite therapy must maintain documentation in the client's record that demonstrates the following criteria:

- Posterior teeth - are not end-to-end, but the buccal cusp of the upper teeth is lingual to the buccal cusp of the lower teeth.

- Anterior teeth - the incisal edge of the upper teeth are lingual to the incisal edge of the opposing arch.

Minor Treatment to Control Harmful Habits

A THSteps Dental Mandatory Prior Authorization Form must be completed when requesting prior authorization for orthodontic appliances for minor treatment to control harmful habits. Documentation must support medical necessity of any appliance requested.

Providers must submit diagnostic models when requesting prior authorization for removable appliance or fixed appliance.

Procedure codes D8210 or D8220 may only be approved for control of harmful habits including, but not limited to, thumb sucking or tongue thrusting and may not be prior authorized for services that are related to comprehensive orthodontic services.

Premature Termination of Orthodontic Services

Premature termination of orthodontic services includes all of the following:

- Removal of the brackets and arch wires.

- Other special orthodontic appliances.

- Fabrication of special orthodontic appliances.

- Delivery of orthodontic retainers.

The prior authorization must include all the following for consideration:

- Panoramic radiograph (copies are preferred).
- Cephalometric radiograph with tracing (copies are preferred).
- Six intra-oral photographs (copies are preferred).
- Three extra-oral photographs (copies are preferred).
- A narrative documenting the provider is terminating the orthodontic services.
- Documentation that the parent, legal guardian, or the client, if he or she is 18 years of age or older or an emancipated minor, understands that the provider is terminating the orthodontic services, and the client is no longer eligible for orthodontic services by Texas Medicaid/THSteps.

In addition to the final record, the provider requesting premature termination of orthodontic services must submit a copy of the signed release form that includes the following:

- A signature by one of the following:
  - The parent
  - Legal guardian
  - The client, if he or she is 18 years of age or older or an emancipated minor

- One of the following statements:
  - The client is uncooperative or non-compliant with the treating dentist’s directions and does not intend to complete orthodontic treatment.
  - The client requested the premature removal of orthodontic appliance(s) and does not intend to complete orthodontic treatment.

**Note:** A client for whom removal of an appliance has been due to the client’s request, or is uncooperative or non-compliant will not be eligible for any additional Medicaid orthodontic services.

  - The client has requested the premature removal of orthodontic appliance(s) due to extenuating circumstances including, but not limited to, the following:
    - Incarceration.
    - Mental health complications with a recommendation from the treating physician.
    - Foster care placement.
    - Child of a migrant farm worker. With the intent to complete orthodontic treatment at a later date if Medicaid eligibility for orthodontic services continues.
    - Special medical conditions

**Note:** If comprehensive orthodontic services are terminated due to extenuating circumstances, clients will be eligible for completion of their Medicaid orthodontic services if the services are re-initiated while the client is eligible for Medicaid.

The requesting provider will be responsible for removal of the orthodontic appliances, final records, and fabrication and delivery of orthodontic retainers at the time of premature removal or at any future time should the client present to the treating provider’s office.
Transfer of Services

Prior authorization that is issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new prior authorization to complete the orthodontic treatment that was initiated by the original provider. The original prior authorization will be end-dated when services are transferred to another provider.

The new provider must obtain his or her own records, and the new request for orthodontic services must include the date of service on which the documentation was obtained (the date of service on which the records were produced) and the following supporting documentation:

- All of the documentation that is required for the original request
- Photographs may be substituted for models
- The reason the client left the previous provider
- An explanation of the treatment status

The authorization request for clients who are undergoing orthodontic treatment services and subsequently become eligible for Medicaid are subject to the same requirements.

Orthodontic Cases Initiated Through a Private Arrangement

Authorization may be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement before becoming eligible for Medicaid.

Authorization will not be given for continuation of orthodontic cases for clients who initiated orthodontic treatment through a private arrangement and were eligible for Medicaid at the start of service.

Non-covered Services

Single arch comprehensive orthodontic treatment is not a benefit of Texas Medicaid.

Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid. Although aesthetics is an important part of self-esteem, services primarily for self-worth are not within the scope of this Texas Medicaid benefit.

Orthodontic services for a client who initiated orthodontic treatment through a private arrangement while Medicaid-eligible are not a benefit of Texas Medicaid.

An initial orthodontic or pre-orthodontic treatment visit (procedure code D8660) is considered part of the exam in an oral evaluation (procedure codes D0120 or D0150).