MOLINA-OH-D |Utilization Review Criteria – Orthodontic Services

Purpose

To ensure consistent and equitable determination of coverage for Orthodontic dental services, following ODM Appendix A to rule 5160 and Molina Healthcare of Ohio Dental Provider Manual Clinical Criteria.

Policy

It is expected that procedures performed will comply with these guidelines and exceptions are minimal. SKYGEN USA, LLC utilizes Ohio 5160-5-01, Molina Ohio Clinical Criteria, and EPSDT standards for members under 21.

Orthodontic Services

- Coverage of comprehensive orthodontic service is limited to treatment of existing or developing malocclusion, misalignment, or malposition of teeth that has, or may have, an adverse medical or psychosocial impact on the patient.
- Orthodontic service is considered to be medically necessary when its purpose is to restore or establish structure or function, to ameliorate or prevent disease or physical or psychosocial injury, or to promote oral health.
- Purely cosmetic orthodontic service is not covered.
- Prior authorization covers the entire course of comprehensive orthodontic treatment, up to a maximum of eight quarters, as long as the patient remains eligible for Medicaid services.
- If the patient becomes ineligible for Medicaid during the course of treatment, coverage and payment will continue through the end of the last quarter during which the patient is eligible.
- It is then the responsibility of the patient and the dentist to determine how payment is to be made for subsequent treatment.
- Payment for active treatment is payment in full. No additional payment can be sought from the patient or a third-party payer if the treatment requires more than eight quarters.
- A request for coverage by the department beyond 8 calendar quarters must be accompanied by extraordinary supporting documentation.
- After active treatment is completed, payment may be made for retention service, once per arch, under the original prior authorization. Payment will not be made for active treatment after retention service is begun.
- When prior authorization for comprehensive orthodontic service is denied, payment may still be made for images, cephalometric films, tracings, and diagnostic models.
- Full-mouth and panoramic images do not require prior authorization; separate claims may be submitted for these items.

Comprehensive orthodontic service, active treatment

- 8 calendar quarters per course of treatment
- Coverage is limited to patients younger than 21.
- Six items must be submitted with each PA request:
    - Lateral and frontal photographs of the patient with lips together.
    - Cephalometric film with lips together, including a tracing.
    - A complete series of intraoral images.
    - At least one diagnostic model.
    - A treatment plan, including the projected length and cost of treatment.
    - A completed evaluation and referral form, the ODM 03630 (01/2016).

Additional Orthodontic Clinical Criteria:

Comprehensive orthodontic services

- Documentation shows deep impinging overbite that shows palatal impingement of the majority of lower incisors
- Documentation shows true anterior open bite (not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted)
- Documentation shows a large anterior-posterior discrepancy (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III)
- Documentation shows anterior cross bite (involves more than two teeth in cross bite)
- Documentation shows posterior transverse discrepancies (involves several posterior teeth in cross bite, not a single tooth in cross bite)
- Documentation shows significant posterior open bites (not involving partially erupted teeth or one or two teeth slightly out of occlusion)
- Documentation shows impacted canines that will not erupt into the arch without orthodontic or surgical intervention (does not include cases where canines are going to erupt ectopically)
- Documentation shows majority of primary posterior teeth have exfoliated and orthodontic treatment is not expected to exceed 24 months; if necessary, interceptive orthodontics has been completed
- Documentation on ODM Form 03630: Referral Evaluation Criteria for Comprehensive Orthodontic Treatment shows at least five symptoms and signs of physical conditions checked, two of which fall under “dentofacial abnormality”

Comprehensive orthodontic service, retention service, per arch

- 1 per arch Coverage is limited to patients younger than 21.
- Retention service may be covered after active treatment has been completed.

Surgical access of an unerupted tooth

- 1 per tooth
- Complete images must be submitted with each PA request.

Placement of device to facilitate eruption of impacted tooth

- 1 per tooth
- Complete images must be submitted with each PA request.

Minor treatment to control harmful habits, removable appliance, minor treatment to control harmful habits, fixed appliance

- Harmful habits include but are not limited to:
- thumb- or finger-sucking,
- tongue thrusting
- bruxism
- Complete images, diagnostic models, or photographs of the mouth must be submitted with each PA request.
- No prior authorization for removable appliances
- Prior authorization required for fixed appliances

Unspecified orthodontic procedure

- This service entails unusual or specialized treatment required when its purpose is to restore or establish structure or function, to ameliorate or prevent disease or physical or psychosocial injury, or to promote oral health.
- Detailed information on the medical necessity of the service
- Complete images of the mouth (if indicated)
- Estimate of the usual fee charged for the service must be submitted with each PA request.