

10-144 Chapter 101
 MAINECARE BENEFITS MANUAL
 CHAPTER II

Section 25

DENTAL SERVICES

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25.01 DEFINITIONS

25.01-1 **Adjusted Acquisition Cost** is the price paid to a dental laboratory by an eligible provider for a custom laboratory fabricated appliance, excluding all associated costs such as, but not limited to, postage, shipping, handling, and insurance costs.

25.01-2 **Complete (or full) Denture** is any denture delivered to a completely healed, completely edentulous alveolar ridge such that relining or rebasing procedures are not required within six (6) months of delivery of the denture.

25.01-3 **Consultation** is an opinion rendered by a dentist whose advice is requested by another dentist or physician for the further evaluation and/or management of the patient. When the consulting dentist assumes responsibility for the continuing care of the patient, any subsequent service rendered by him/her will cease to be a consultation. The Department requires a written report to be sent to the requesting practitioner.

25.01-4 **Dental Services** are all services provided by or under the supervision of a dentist in the practice of dentistry. Such services include treatment of the teeth and associated structures of the oral and maxillofacial regions, and of disease, injury, abnormality, or impairment that may affect the oral or general health of the individual.

For the purposes of this policy, Dental Services also include denturism, hygienist services provided by Maine's schools of dental hygiene, hygienist services provided by public health entities, and school-based and/or school-linked programs under contract arrangement with the Maine Center for Disease Control and Prevention, Oral Health Program.

25.01-5 **Dentist** is any person currently licensed by the Maine State Board of Dental Examiners or by the state or province in which services are provided to practice dentistry as herein defined.

25.01-6 **Dentistry** is the evaluation, diagnosis, prevention and/or treatment (non-surgical, surgical, or related procedures) of diseases, disorders, and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body; provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession, applicable law, and licensure regulation.

25.01-7 **Denturism** is the taking of denture impression and bite registration for the purpose of making, producing, reproducing, constructing, finishing, supplying, altering, or repairing of a complete upper or complete lower prosthetic denture, or both, to be fitted to an edentulous arch or arches.

25.01-8 **Denturist** is any person currently licensed by the Maine State Board of Dental Examiners or by the state or province in which services are provided to practice denturism as herein defined.

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25.01 DEFINITIONS (cont.)

- 25.01-9 **Department** means the Department of Health and Human Services, acting through the Office of MaineCare Services (OMS).
- 25.01-10 **Immediate Complete Denture** is any complete denture delivered the same day of dental extraction or to a not fully healed (completely edentulous) alveolar ridge such that relining or rebasing procedures may be required after an appropriate time interval for healing.
- 25.01-11 **Immediate Removable Partial Denture** is any removable partial denture delivered the same day of dental extraction or to a not fully healed alveolar ridge such that relining or rebasing procedures may be required after an appropriate time interval for healing.
- 25.01-12 **Public Health Supervision** means supervision of a hygienist who (1) has an active Maine license; (2) is practicing in a Public Health Supervision status as described in the Maine Department of Professional and Financial Regulation, 02-313 CMR 2, under the general supervision of a dentist, although the patient being treated may not be a patient of record of the supervising dentist; and (3) is practicing in a non-traditional dental setting. These settings may include but are not necessarily limited to public and private schools, medical facilities, nursing homes, residential care facilities, dental vans, and any other setting where adequate parameters of care, infection control, and public health guidelines can and will be followed.
- 25.01-13 **Professional Reviewer** is a licensed dentist who is involved in reviewing treatment records or evaluating requests for treatment requiring prior approval as a professional reviewer.
- 25.01-14 **Referral** is the transfer of the total or specific care of a patient from one dentist to another and does not constitute a consultation.
- 25.01-15 **Removable Partial Denture** is a removable replacement, including overdentures, for missing teeth in an arch which still has some natural teeth remaining, or in any arch that has had implants placed regardless of whether or not there are any remaining teeth.
- 25.01-16 **Same Period of Treatment** is the time period required for those sequential visits necessary to perform all of the needed services identified during a diagnostic examination and included in the written treatment plan.
- 25.01-17 **Servicing (or rendering) provider** is an individual who provides medical services to MaineCare members. All MaineCare servicing or rendering providers are required to file Servicing Provider forms with the Department. Servicing providers can not submit bills or claims to MaineCare, unless they are also MaineCare providers.

25.01 DEFINITIONS (cont.)

MaineCare providers submit bills to MaineCare for services rendered by their employees who are servicing or rendering providers.

- 25.01-18 **Specialist** is a dentist who practices one of the American Dental Association (ADA) recognized specialties and has fulfilled all of the required training to be recognized as such.

25.02 ELIGIBILITY FOR CARE

MaineCare members are eligible for covered dental services as set forth in this Manual. The Department requires that individuals must meet the eligibility criteria and residency requirements as set forth in the MaineCare Eligibility Manual. The Department may have restrictions on the type and amount of services that some members are eligible to receive.

25.03 COVERED SERVICES

Covered services are available for:

- A. eligible members under the age of twenty-one (21);
- B. eligible members of any age residing in an Intermediate Care Facility for Persons with Mental Retardation (ICF-MR); and
- C. limited services for eligible members over the age of twenty-one (21).

Adult members not residing in an ICF-MR and age twenty-one (21) or older are eligible only under the adult dental care guidelines described in Chapter II, Subsection 25.04. Reimbursement is not available for any member age twenty-one (21) or older for orthodontics, orthognathic surgery or repair of cleft palate procedures except in those cases where treatment is being performed to correct a post-traumatic or post-surgical disfigurement or in those cases where it is a continuation of ongoing treatment. All covered services are subject to the restrictions and requirements contained in Chapters II and III, Section 25 of this manual.

- 25.03-1 **Diagnostic Services** are available for eligible members under the age of twenty-one (21) and members of any age residing in an ICF-MR and are subject to the restrictions indicated in Chapters II and III, Section 25. Adult members, not residing in an ICF-MR and age twenty-one (21) or older are eligible only for selected procedures that are available under the adult dental care guidelines contained in Subsection 25.04.

A. **Clinical Oral Examination(s)**

Reimbursement for examinations or evaluations is available only when performed by a licensed dentist or denturist in accordance with Chapter III.

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25.03 COVERED SERVICES (cont.)

1. Reimbursement for periodic oral examinations will not be made more than once every six months.
2. Reimbursement for limited oral or problem focused (emergency) exams is available once per emergency episode per provider.
3. Comprehensive oral exams are for new or established patients when evaluating a member comprehensively. This applies to new patients, established patients who have had a significant change in health conditions or other unusual circumstances, or by established patients who have been absent from active treatment for three (3) or more years.
4. Reimbursement for detailed and extensive oral exams (problem focused) used to evaluate medical appropriateness for restorative, surgical, and prosthodontic services is available once per episode per provider.

Reimbursement for exams includes the preparation of charts, treatment plans, and reporting forms.

B. Radiographs

1. The limitations placed on radiographs are intended to confine radiation exposure of members to the minimum level necessary to achieve a satisfactory diagnosis for dental services. Radiographs submitted to the Department must be of good diagnostic quality, properly processed, mounted, dated, labeled for right and left views, and fully identified with the names of the dental office and the member.
2. When radiographs submitted to the Department are not of diagnostic quality, the provider may not seek payment for retake radiographs requested by the Department's professional reviewer.
3. The type of radiographic survey that is used is at the discretion of the provider, within the accepted American Dental Association (ADA) practice parameters.
4. Posterior bitewing radiographs as an independent procedure are reimbursable only once per calendar year.
5. If the member is going to have dental extraction prior to fabrication of immediate or partial dentures, the responsible dentist making the prior authorization request must send the pre-extraction radiographs to the Department.

25.03 COVERED SERVICES (cont.)

6. A complete intraoral series shall consist of a minimum of twelve (12) periapical radiographs plus posterior bitewings. A complete intraoral radiographic series is reimbursable once every three (3) years, except as part of an approved orthodontic treatment plan.
7. Panoramic radiographs are:
 - a. included in the reimbursement for comprehensive orthodontic services; and
 - b. separately reimbursable for interceptive orthodontics, oral surgery, and as allowed under adult care guidelines.
8. A temporomandibular joint (TMJ) radiograph series includes right and left transcranial films in the open, closed, and rest positions. Prior authorization is not required.

C. **Sialography radiographs** employing a contrasting medium are reimbursable when taken of a salivary gland or duct, not for a simple salivary stone.

D. **Pulp vitality** tests are to be used when the vitality of the tooth is in question. The Department does not consider these tests as routine procedures and the member's record must document the signs and symptoms that contributed to the questioning of the tooth's vitality.

E. **Diagnostic cast models** must be of good diagnostic quality and properly related in occlusion by either trimming the heels of each model flush or by an accurate bite registration submitted to the Department.

25.03-2 **Preventive Services** are reimbursable for eligible members under the age of twenty-one (21) and members of any age residing in an ICF-MR and are subject to the restrictions in Chapters II and III, Section 25. Adult members, not residing in an ICF-MR and age twenty-one (21) or older are eligible only for selected procedures that are available under the adult dental care guidelines contained in Subsection 25.04.

A. **Prophylaxis**

1. Prophylaxis is the removal of plaque, calculus and stains from the tooth structures in the permanent, primary and transitional dentition and is intended to control local irritational factors. Prophylaxis is reimbursable no more frequently than once every six months. This service may include a scaling of the teeth, and must include the removal of acquired stains and deposits, polishing of the teeth, and oral hygiene instructions to the member.

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A “toothbrush prophylaxis” is not recognized as a covered service and cannot be billed as a prophylaxis. If performed, it would be included as part of the exam, or included in oral hygiene instructions and is not separately billable.

2. Prior approval for prophylaxis more frequently than once every six months may be requested for members who are significantly physically or mentally handicapped, such that routine preventive home care is impossible as a result of the handicapping condition. Prophylaxis more frequently than twice a year may also be requested for those members who exhibit a repetitively high caries rate or when significant medical conditions other than physical or mental handicaps exist which make the member more susceptible to dental disease.
- B. **Topical fluoride** treatment is reimbursable no more frequently than twice per year except in those cases where a high caries rate indicates that more frequent applications would be valuable (e.g., additional applications of topical fluoride are allowed when a child has current decay or has had new restorations placed in the previous eighteen (18) months).
- C. **Pit and fissure sealants** are reimbursable for permanent teeth, once every three (3) years per member per provider, and once per lifetime for deciduous (baby) teeth.
- D. **Fixed space maintainers and removable bilateral space maintainers** are reimbursable for members under age twenty-one (21) and for all members residing in an ICF-MR.
- E. **Oral hygiene instruction** is reimbursable as an independent service provided a charting is recorded of the member’s oral hygiene indicating poor application of the skills necessary to maintain good oral health. Up to three (3) visits per year are reimbursable per member per provider. Oral hygiene instruction is included as part of prophylaxis and is therefore not separately billable on the same day that prophylaxis is performed. Oral hygiene instruction must include disclosure of plaque, hands-on training in plaque removal and education on the etiology of dental disease.
- F. **Behavior management** of the member is critical to providing successful dental treatment. In some cases it may take several visits to establish a relationship that will allow delivery of appropriate care. Establishing that relationship may negate the necessity for more costly interventions (i.e., general anesthesia, utilization of a specialist). The Department will reimburse up to three (3) visits per general dentist to gain the trust and cooperation of the member.

25.03 COVERED SERVICES (cont.)

- G. Smoking Cessation Counseling** is a covered service only when performed by the dentist, for members age eight (8) to twenty-one (21) and in accordance with the following requirements:

MaineCare covers counseling and treatment for smoking dependence to educate and assist members with smoking cessation. Services may be provided in the form of brief individualized behavioral therapy, which must be documented in the member's record. Providers must educate members about the risks of smoking, the benefits of quitting and assess the member's willingness and readiness to quit. Providers should identify barriers to cessation, provide support, and use techniques to enhance motivation for each member. Providers may also use pharmacotherapy for those member's for whom it is clinically appropriate and who are assessed as willing and ready to quit, or in the process of quitting.

The amount of time spent with the member does not affect reimbursement. Reimbursement is available once per member, per calendar year, per dentist. Reimbursement is not available for this service when provided through the Maine Center for Disease Control and Prevention's, Oral Health Program.

25.03-3 **Restorative Services** are available for eligible members under the age of twenty-one (21) and members of any age residing in an ICF-MR and are subject to the restrictions and regulations listed in Chapters II and III, Section 25. Adult members, not residing in an ICF-MR and age twenty-one (21) or older are eligible only for selected procedures that are available under the adult dental care guidelines described in Subsection 25.04.

A. Amalgam and Composite Restorations

1. Local anesthesia and bases are to be used when indicated and are not separately reimbursable.
2. No combination of restorations on a single tooth during the same period of treatment is reimbursable in excess of the fee for a four (4) surface restoration.
3. Two single-surface restorations performed on different surfaces on the same tooth, (such as occlusal and buccal on a mandibular molar), that are accomplished during the same period of treatment, must be coded as a two (2) surface restoration.
4. For anterior teeth, cuspids, lateral, and central incisors, only a one (1) surface restoration for a mesial or a distal lesion is reimbursable,

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even though a facial or a lingual approach is used when the decay extends onto the facial or labial surface.

5. Composite resin restorations may be used in all primary and permanent teeth.
6. The provision of acid etch retention is considered to be part of the reimbursement for the composite resin restorations. No additional reimbursement will be made for this service.
7. Reinforcing pins are reimbursable when used on permanent teeth where necessary for the retention of the restoration.

B. Crowns

1. Reimbursement for prefabricated stainless steel or composite resin crowns does not require prior authorization and is subject to the restrictions indicated in Chapters II and III, Section 25.
2. Reimbursement for stainless steel or resin crowns is available for adult members age twenty-one (21) or over not residing at an ICF-MR when provided:
 - a. in conjunction with the adult dental care requirements in Subsection 25.04; and
 - b. to restore an endodontically treated tooth during the same period of treatment as the original endodontic services.
3. When a stainless steel crown is used as a base for a space maintainer, the dentist may bill for a crown or a base, but not both.
4. Resin or stainless steel crowns are reimbursable for deciduous anterior teeth including cuspids.
5. Reimbursement is not available for full cast metal, porcelain to metal, porcelain or temporary crowns (except for resin and stainless steel crowns as previously indicated).

C. Sedative fillings are temporary restorations intended to sedate the pulp or to protect the vitality of the tooth. The code for sedative fillings is not to be used to identify or bill for the placement of a base material under a final restoration and is to be billed by general dentists.

25.03-4 **Endodontic Services** are available for eligible members under the age of twenty-one (21) and members of any age residing in an ICF-MR and are subject to the restrictions

25.03 COVERED SERVICES (cont.)

and regulations listed in Chapters II and III, Section 25. Adult members, not residing in an ICF-MR and age twenty-one (21) or older are eligible only for selected procedures that are available under the adult dental care guidelines described in Subsection 25.04.

A. Direct Pulp Capping

1. Direct pulp capping is only to be used when there is a pulpal exposure.
2. Reimbursement for protective bases is included in reimbursement for restoration procedures.

B. Pulpotomy

1. Pulpotomy is the complete removal of the coronal portion of the pulp to maintain the vitality of the tooth. It can be billed only in instances when a root canal is not anticipated. A pulpotomy is not reimbursable when performed on a primary tooth with roots showing signs of advanced resorption (more than two-thirds of the root structure resorbed).
2. A pulpotomy is not reimbursable in conjunction with root canal therapy during the same period of treatment when the same provider performs the pulpotomy and the root canal.
3. A pulpotomy is not reimbursable when used for the temporary relief of pain pending endodontic treatment when the same provider performs the pulpotomy and root canal.
4. A sedative filling is not reimbursable when performed in conjunction with a pulpotomy.

C. Root Canal Treatment

1. Root canal treatments are limited to permanent dentition and then only when there is a favorable prognosis for the continued health of the remaining dentition. In the course of the root canal treatment, in addition to reimbursement for the root canal procedure, reimbursement is separately available as necessary for the following procedures:
 - a. the simple restoration of the tooth;
 - b. the placement of a prefabricated post and core;

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- c. the cost of pins;
- d. a stainless steel crown; or
- e. a resin crown.

2. If root canal treatment is initiated but not completed, the provider may submit a claim indicating the extent of the treatment completed. The Department will determine a prorated reimbursement. These claims are submitted to the prior authorization unit. Prior authorization contact information can be found at:
http://www.maine.gov/dhhs/oms/provider_index.html

D. **Apexification** procedures require that there is sufficient tooth structure remaining to support the subsequent root canal treatment and restoration.

E. **An apicoectomy** follows root canal treatment when the canal is not to be re-instrumented. Prior authorization must be obtained from the Department. Reimbursement for retrograde fillings is available as a separate procedure.

25.03-5 **Periodontic** services are restricted to eligible members under the age of twenty-one (21) and members of any age residing in an ICF-MR and are subject to the restrictions and regulations listed in Chapters II and III, Section 25. Adult members, not residing in an ICF-MR and age twenty-one (21) or older are eligible only for selected procedures that are available under the adult dental care guidelines described in Subsection 25.04.

A. Scaling is considered an integral part of prophylaxis as described in Subsection 25.03-2, Preventive Services.

B. Reimbursement is available for scaling and root planing as an independent procedure:

- 1. for members up to age twenty-one (21); and
- 2. when prior authorization is granted.

C. Prior authorization for scaling and root planing may be requested when the member's record, as submitted to the Department, indicates:

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1. generalized pocket depths of four (4) millimeters or greater as evidenced by charting; and
 2. calculus visible on fifty percent (50%) of interproximal surfaces as evidenced by radiographs; and
 3. evidence of infection present.
- D. Other periodontal procedures listed in Chapter III of this Section are subject to the restrictions therein.

25.03-6 **Prosthodontics** is available for eligible members under the age of twenty-one (21) and for members of any age residing in an ICF-MR and are subject to the restrictions indicated in Chapters II and III, Section 25. Adult members, not residing in an ICF-MR and age twenty-one (21) or older are eligible only for selected procedures as indicated in Chapters II and III, Section 25, most of which are available only under the adult dental care guidelines as described in Chapter II, Subsection 25.04-1.

If the provider receives prior authorization for prosthodontic services and takes the final impressions while a member is MaineCare eligible, the Department will reimburse the provider even if the member subsequently becomes ineligible for MaineCare. The Department will only reimburse the provider after the prosthesis is delivered. The provider must indicate on the invoice the date that impressions were taken as the date of service for billing purposes.

- A. All requests for prior approval for partial dentures must include a treatment plan and radiographs.
- B. Reimbursable removable prosthodontics includes partial dentures, immediate dentures, full dentures, and overdentures.
 1. All dentures including partial, immediate, full and overdentures require prior approval.
 2. If approval for partial dentures has been authorized, then all necessary operative dentistry must be completed prior to the placement of partial dentures.

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3. Prior approval for partial dentures may be requested for members with two (2) or more missing teeth per dental arch or for members with one (1) or more missing anterior permanent teeth.
4. Adjustments, relining, or rebasing within six (6) months of the initial delivery date is considered routine post-delivery care and reimbursement is included in the initial procedure reimbursement.
5. Adjustments, relining or rebasing six (6) months after the initial delivery date is separately reimbursable once every three (3) years from the date of delivery.

Additional adjustments, relining and rebasing is reimbursable once every three (3) years measuring from the initial date of delivery.

6. Reimbursement for immediate dentures includes reimbursement for both an initial relining and rebasing and the reimbursement for a second relining and rebasing after an appropriate time interval for healing. If a third relining or rebasing is required within three (3) years of the date of initial placement, prior authorization is required for reimbursement. If approved, separate reimbursement can be made for the third relining or rebasing. Further relining and/or rebasing is reimbursable only once every three (3) years from the date of initial placement.
 7. Partial denture, full denture, immediate and overdenture fabrication is reimbursable once every five (5) years.
 8. Reimbursement for overdenture attachment procedures is included in reimbursement for the initial procedure.
 9. Reimbursement for procedures related to removable partial dentures or overdentures will only be paid to licensed dentists.
- C. Reimbursement for fixed prosthodontics is restricted to acid etched composite luted bridgework and requires prior approval.
- Prior approval may be granted to replace a single missing permanent tooth only until the member's twenty-first (21st) birthday.
- D. Non-covered prosthodontic services include:
1. temporary immediate dentures; and
 2. the placement or restoration of dental implants.

25.03 COVERED SERVICES (cont.)

25.03-7 **Oral Surgery** services are available to eligible members under the age of twenty-one (21) and for members of any age residing in an ICF-MR and are subject to the restrictions indicated in Chapters II and III, Section 25. Adult members, not residing in an ICF-MR and age twenty-one (21) or older are eligible only for selected procedures as indicated in Chapters II and III of this Section that are available under the adult dental care guidelines described in Chapter II, Subsection 25.04.

- A. Extraction of teeth that exhibit acute signs of dental disease, infection, decay, or traumatic injury are covered services for adult members when performed under the adult urgent care requirements in Subsection 25.04. MaineCare will cover the removal of erupted and impacted teeth for members of all ages, when a reasonable and documented treatment plan exists. The dentist must document the necessity for the extraction. All tooth removal documentation must include some form of current radiograph of reasonable quality (radiograph is reimbursable for this purpose if there is none of reasonable quality available).

The following indications are acceptable when supported by member record entries:

1. dental caries;
2. periodontal disease;
3. traumatic fracture, luxation, partial avulsion;
4. crowding or part of a serial extraction treatment plan;
5. evidence of pathology;
6. anomalies of tooth position;
7. to remove potential sources of infection in a member for whom radiation, chemotherapy, or transplant is contemplated or who is significantly immuno-compromised in some fashion;
8. impacted teeth;
9. supernumerary teeth;
10. severe attrition; and
11. congenital conditions affecting the reasonable longevity of the tooth, e.g. amelogenesis imperfecta.

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- B. The allowances listed under Oral Surgery, in Chapter III of this Section, for all types of extraction include local anesthesia and routine postoperative care such as suture removal, irrigation, and spicule removal.
- C. Reimbursement for alveoplasty, when performed in conjunction with extraction or within four (4) months of extraction, is separately reimbursable when six (6) or more teeth per dental arch are extracted.
- D. When five (5) or fewer teeth are extracted per dental arch, reimbursement for alveoplasty is included in the payment for extraction.
- E. Reimbursement for alveoplasty, to correct deformities on edentulous recipients requires prior authorization. Prior authorization will be granted only when alveoplasty is performed as a preparation for a prosthesis.
- F. Extractions of teeth related to a major surgery are covered procedures, if the outcome of the major surgical procedure or the ongoing treatment of the member is directly affected by the extractions, and:
 - 1. the major surgical procedure is a MaineCare covered procedure; and
 - 2. the extraction is performed within six (6) months before the major surgical procedure, unless:
 - a. it is a life threatening situation for the member; or
 - b. the member will be receiving chemotherapy or radiation treatment; or
 - c. the extraction is performed as part of a work-up for a major organ transplant and a donor organ is not available within the six (6) month period.
- G. The allowances listed in the Oral Surgery Section of Chapter III of this Section provide payment for the following:
 - 1. pre-operative visits in the hospital;
 - 2. surgery;
 - 3. follow-up care, for thirty (30) days following surgery regardless of treatment setting.

Exception: The allowances for diagnostic procedures (e.g., biopsy) include the procedure and the follow-up care related to recovery from the procedure

25.03 COVERED SERVICES (cont.)

itself. When an additional surgical procedure(s) is carried out within the thirty (30) day follow-up period for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

1. The Department allows concurrent services by multiple surgeons/dentists, when warranted in the following situations:
 - a. consultation;
 - b. medically necessary services provided prior to surgery, and/or following the surgery (management of a medical problem, monitoring during surgery, etc.); and
 - c. an allowance for a dentist as a surgical assistant will be made for major surgery at twenty percent (20%) of the surgical allowance. When billing for a surgical assistant, please use the most current Departmental billing instructions and include the name of the primary surgeon.
2. Orthognathic surgery is only reimbursable when done in conjunction with orthodontic treatment, or when the surgery is being performed to correct a post-traumatic or post-surgical disfigurement. Providers must include requests for orthognathic surgery in conjunction with orthodontic treatment in the prior authorization request for orthodontic services. If orthognathic surgery is anticipated it must be indicated on the treatment plan. Active orthodontic treatment must begin within twelve (12) months of prior authorization by the Department, and be performed in accordance with Subsection 25.03.

The Department does not cover orthognathic surgery for cosmetic purposes. All orthognathic surgery requires prior authorization. The Department covers orthognathic surgery for medically necessary indications such as:

- a. Jaw and craniofacial deformities causing significant functional impairment for the following clinical indications:
 - (1) repair or correction of a congenital anomaly that is present at birth; or
 - (2) restoration and repair of function following treatment for a significant accidental injury, infection, or tumor.

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- b. Anteroposterior, vertical, or transverse discrepancies or asymmetries that are two (2) or more standard deviations from published norms and that cause one (1) or more of the following documented functional conditions:
 - (1) difficulty swallowing and/or choking, or ability to chew only soft or liquid food for at least the last four (4) months; or
 - (2) speech abnormalities determined by a speech pathologist or therapist; or
 - (3) malnutrition related to the inability to masticate, documented significant weight loss over the last four (4) months and a low serum albumin related to malnutrition; or
 - (4) intra-oral trauma while chewing related to malocclusion; or
 - (5) significant obstructive sleep apnea not responsive to treatment.
 - c. Reimbursement is not available for orthognathic surgery after the member's twenty-first (21st) birthday except for facial reconstruction following facial trauma that has resulted in facial disfigurement, pain, or malfunction.
 - d. Reimbursement is not available for model surgery or other pre-surgical treatment planning.
 - e. Reimbursement is separately available for necessary surgical stents and necessary pre- and post-surgical radiographs.

Documentation must include, but is not limited to study models with appropriate bite registration, intra-oral extraoral photographs, panoral and cephalometric radiographs, the provider's usual and customary fees and any other pertinent information regarding the member's condition.
3. Other Repair Procedures
- a. Osteotomy of maxilla covers the entire maxillary surgical procedure for the correction of a maxillary skeletal malocclusion. This service includes, but is not limited to,

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the “LeFort Procedure” and any sectioning, advancement, retrusion, elevation, or other movement of the maxilla and its fixation. These procedures are mutually exclusive; that is, only one of these procedures can be used for a specific surgery. These procedures include a bilateral inferior turbinectomy, and/or septoplasty, if necessary.

- b. Osteotomy of maxilla, including graft, covers the entire maxillary surgical procedure for the correction of a maxillary skeletal malocclusion. This service includes, but is not limited to, the “LeFort Procedure” and any sectioning, grafting, advancement, retrusion, elevation, or other movement of the maxilla and its fixation. This procedure includes a bilateral inferior turbinectomy, and/or septoplasty, if necessary.
- c. Osteotomy of mandible covers the entire mandibular surgical procedure for the correction of a mandibular skeletal malocclusion. This procedure includes, but is not limited to, a bilateral sagittal or oblique osteotomy, any necessary myotomies, necessary osteotomies of the inferior border of the mandible, coronoidotomies, and any sectioning, advancement, retrusion, elevation, or other movement of the mandible and its fixation. A genioplasty procedure is included in this procedure only if it is done as a part of a larger orthognathic surgical procedure. A genioplasty procedure is a covered service only if it is done for functional reasons. These procedures are mutually exclusive, that is, only one of these procedures can be billed for a specific surgery.
- d. Osteotomy of mandible including graft covers the entire mandibular surgical procedure for the correction of a mandibular skeletal malocclusion. This procedure includes, but is not limited to, a bilateral sagittal or oblique osteotomy, any necessary myotomies, necessary osteotomies of the sectioning, grafting, advancement, retrusion, elevation, or other movement of the mandible and its fixation. A genioplasty procedure is included in this procedure only if it is done as a part of a larger orthognathic surgical procedure. A genioplasty procedure is a covered service only if it is done for functional reasons.

25.03-8 **Orthodontic Services** are restricted to eligible members under age twenty-one (21) and requires prior approval.

25.03 COVERED SERVICES (cont.)

A. Limited and Interceptive Orthodontics (not comprehensive)

1. **Limited:** According to the American Dental Association's Current Dental Terminology publication (CDT-5), limited orthodontic services entails treatment with a limited objective, not involving the entire dentition. Providers may direct treatment only at the existing problem, or at only one (1) aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

Examples of this would be treatment in one (1) arch only to correct crowding, partial treatment to open spaces or upright a tooth for a bridge or implant and partial treatment for closure of a space(s).

2. **Interceptive:** According to the American Dental Association's Current Dental Terminology publication (CDT-5), interceptive orthodontic treatment is indicated for procedures to lessen the severity or future effects of a malformation, eliminate its cause, and may include localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite or recovery of recent minor space loss where overall space is adequate.

The Department considers successful interception to be intervention in the incipient stages of a developing problem to lessen the severity of the malformation and eliminate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require future comprehensive therapy.

Both limited and interceptive orthodontics require prior authorization. Prior approval for interceptive orthodontics is not considered approval for comprehensive orthodontics in a two-phase plan. If a second phase is anticipated after treatment has begun, submission of a completed Handicapping Labiolingual Deviation (HLD) Index Report (see Appendix II for copy of form) is mandatory. In the event that less than eighteen (18) months have elapsed between the last treatment of interceptive orthodontics and the commencement of an approved comprehensive plan, the reimbursement received for the interceptive plan will be deducted from the reimbursement for the comprehensive plan. In the event that eighteen (18) months or more have elapsed between the two approved plans, the provider will be reimbursed independently for the comprehensive treatment plan. Providers requesting approval for comprehensive orthodontics after a period of interceptive treatment

25.03 COVERED SERVICES (cont.)

should indicate the last date of active interceptive treatment on the HLD Index Report.

3. Prior approval for limited and interceptive orthodontics does not require the submission of an HLD Index Report, however, requests must include:
 - a. a description of the problem;
 - b. a description of the appliance;
 - c. a treatment plan for this problem including the number of treatments and total visits;
 - d. the provider's usual and customary fee;
 - e. the submission of models; and
 - f. panoramic films (upon Department request only).
4. Reimbursement for limited and interceptive orthodontics:
 - a. Reimbursement is available for fixed or removable appliance therapy and is based on the type of appliance and treatment plan up to the maximum allowance.

The one-time reimbursement for both limited and interceptive orthodontics includes the appliance, the placement of the appliance, all active treatment visits, and all the follow-up visits even if the member becomes ineligible or reaches age twenty-one (21). The Department does not allow additional or separate reimbursement for this procedure.
 - b. When a retainer is lost or broken beyond repair, by a member who is still within an approved retention phase of a limited orthodontic treatment, the Department will reimburse the provider the adjusted acquisition cost of the appliance and an additional fee to cover the cost of the impression and bite registration materials.

25.03 COVERED SERVICES (cont.)

- c. A provider who normally utilizes an “in house” laboratory for the fabrication of custom-made appliances may submit a statement of the cost of the appliance in lieu of the laboratory invoice noted above. The Department shall reimburse such providers in accordance with the prices of established orthodontic laboratories.

B. Comprehensive Orthodontics

Comprehensive orthodontics is a covered service only after the Department has granted prior approval. A condition must be extreme, and if left untreated, would become an acute dental problem and/or cause irreversible damage to the teeth or supporting structures. The MaineCare Handicapping Labiolingual Deviation (HLD) Index Report (Appendix II) is to be utilized by dentists to determine the extent of the malocclusion.

1. Orthodontic Consultation/Evaluation

- a. When an eligible member is determined to possess a malocclusion, the attending dentist must fill in the HLD Index Report.
- b. When a member scores less than twenty-six (26) points, the attending dentist must determine if there are other conditions present, such as clefts, occlusal interferences, functional jaw limitations, facial asymmetry, speech impairment, severe maxillary, mandibular, or bi-maxillary protrusion, or other physical deviations.

The attending dentist must also identify in his or her opinion, whether there are any indications of potential impairment of mood and/or conduct that may result from emotional distress related to the malocclusion. Such determination(s) must be indicated on the HLD Index Report. The Attending dentist must submit the completed HLD report along with all other additional information listed in 25.03-8(B)(1)(d) of this section to the Department for a determination of malocclusion with additional number of deviations. The number and severity of these deviations will be considered when the determination of an extreme condition is made. Prior to making such determination, the Department may obtain additional information from other professionals and/or request that further evaluation is done.

If a question of impairment of mood and/or conduct as a result of emotional distress has been raised, the Department

25.03 COVERED SERVICES (cont.)

shall ask an outside provider that specializes in this field whether impairment exists; what is its nature and severity; how, if at all, it relates to the malocclusion; and whether treatment of the malocclusion is likely to alleviate the impairment.

- c. If no other conditions exist and the member scores less than twenty-six (26) points on the HLD Index Report, the attending dentist must inform the member that he or she does not qualify for MaineCare coverage of orthodontic treatment. The HLD Index Report must be retained in the member's dental record. The attending dentist may bill separately for the pre-orthodontic treatment visit (includes the completion of the HLD report) at this time.
- d. Prior authorization will be expedited for those HLD Index Reports that meet the qualifying criteria and indicate the presence of cleft palate deformities, a deep impinging overbite, individual anterior teeth crossbite, severe traumatic deviations or an overjet greater than nine (9) millimeters. When a member scores twenty-six (26) or more points on the HLD report (or there are other conditions as noted above), the attending dentist must submit the following information for prior authorization:
 - (1) Handicapping Labiolingual Deviation Index Report;
 - (2) the diagnosis;
 - (3) a panoramic x-ray (when indicated) and cephalometric radiographs with a tracing (when orthognathic surgery is anticipated);
 - (4) diagnostic casts;
 - (5) the preparation of a written comprehensive orthodontic treatment plan including the appliances to be utilized, records, number of visits and the length of retention necessary;
 - (6) information regarding possible orthognathic surgery;
 - (7) a list of any medical or dental treatment necessary to complete the orthodontic treatment (e.g., extractions, gingivectomy, or orthognathic surgery); and

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(8) the provider's usual and customary fees for the case.

The dentist must submit the above information to the prior authorization unit. Prior authorization contact information for can be found at:

http://www.maine.gov/dhhs/oms/provider_index.html

e. The professional reviewer at the Office of MaineCare Services will examine the HLD Index Report for accuracy and completeness. The professional reviewer will do one of the following:

(1) return the form to the dentist for additional information; or

(2) authorize the orthodontic services; or

(3) deny authorization for orthodontic services.

f. The dentist may request separate reimbursement, without prior approval, for each of the following: the pre-orthodontic treatment visit that includes the completion of the HLD Index Report, preparation of the diagnostic casts, panoramic films (if performed), treatment plan and records.

2. Comprehensive Orthodontic Treatment

MaineCare will approve orthodontic treatment for all eligible MaineCare members under age twenty-one (21) that meet the Departmental guidelines.

MaineCare enrolled orthodontic providers treating, or about to treat a child participating in the Division of Family Health, Children with Special Health Needs Program, must follow all requirements for orthodontic services described in this section of the MaineCare Benefits Manual for orthodontic treatment.

a. Routine dental treatment such as cleaning and restorations are not part of an orthodontic treatment plan.

b. Prior authorization will be approved only for cases that have an adequate treatment plan that indicates a treatment sequence that will correct the malocclusion.

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- c. Members who are under active orthodontic treatment that started prior to the member's date of eligibility for MaineCare, and subsequently became eligible for MaineCare Dental Services under Chapter II, Section 25.02, and are less than twenty-one (21) years of age may have the completion of their orthodontic treatment covered by MaineCare. MaineCare will only cover the continued treatment if the member's orthodontic records and pre-treatment models show that the member would have met the prior authorization criteria for the orthodontic examination and treatment.
- d. Comprehensive orthodontic treatment must begin within twelve (12) months after approval by the Department.

Treatment will be considered to have begun with the extraction of teeth for orthodontic purposes, the placement of a major orthodontic appliance, such as fixed orthodontic brackets, palatal expanders, or other functional appliances requiring active management. Once active orthodontic treatment has begun, an all-inclusive reimbursement fee will be made for the initial appliance, placing of the brackets, all treatment visits, one appliance repair or replacement, one retainer repair or replacement. Rebonding or recementing of a retainer is also considered a repair.

Once active orthodontic treatment has begun, the provider must continue to cover the orthodontic treatment even if the member becomes ineligible for MaineCare. The member must continue to meet the residency requirements in the MaineCare Eligibility Manual. If treatment is stopped or suspended or the patient moves or is dismissed from a practice, the provider must notify the Office of MaineCare Services. MaineCare will pro-rate, on a case by case basis, the amount the provider will be required to reimburse the Department based on the start date of the orthodontia treatment and the actual services and visits that have been completed.

3. Policies and Procedures

- a. Upon the receipt of authorization from the Department, the dentist will proceed to treat the orthodontic condition according to the plan, making necessary arrangements for such services as extractions. Orthodontic treatment, including the placement of the appliance, must be started within twelve (12) months of the date of the authorization of

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that treatment. A new request for prior authorization must be submitted to the Department if treatment has not been started within twelve (12) months of the original authorization. No reimbursement is available for a second authorization. If the member, subsequent to the second request, becomes ineligible, an additional approval will not be granted.

- b. Once treatment has begun, the provider may bill and receive an all-inclusive payment for the orthodontic services. This all-inclusive payment includes the comprehensive orthodontic treatment (placement of appliances), all treatment visits, one appliance repair or replacement, one retainer repair or replacement. Rebonding or recementing of a retainer is also considered a repair. The provider must indicate in the member's record the date of the first appliance and retainer repair or replacement. Subsequent repairs and replacements are separately billable and must be documented in the member's record.
- c. Reimbursement for de-banding for members currently receiving orthodontic care under an approved treatment plan is included in the all-inclusive payment for orthodontic services and is not separately reimbursable. Separate reimbursement is available for members under twenty-one (21) who are not currently receiving orthodontic care under an approved treatment plan. Reimbursement is available per dental arch.
- d. Retainer checkups are part of the orthodontic package and reimbursement is included in the all-inclusive payment for orthodontia services.
- e. Monitoring growth and development is not considered active treatment and, therefore, is not reimbursable.
- f. The provider can obtain assistance with addressing the member's non-compliance with the member's treatment plan by contacting MaineCare's Prevention, Health Promotion, and Optional Treatment Services for members under age twenty-one (21). A preventive care referral will then be made to the Department's Nursing Division for assistance.

25.03 COVERED SERVICES (cont.)

4. Records and Reports

The provider must maintain a specific record for each member including but not limited to: name, address, birth date, MaineCare ID number, pertinent diagnostic information, radiographs, a current treatment plan, signed periodic progress reports, and documentation for dates of service.

- a. Member's records will be kept current and available to the Department as documentation of services included on claim forms. Records will be kept in accordance with the statute of limitations and pursuant to State and Federal rules and regulations.
- b. The MaineCare Prior Authorization Unit will maintain a specific record for each member approved for orthodontic treatment that will include, but not be limited to: name, address, caretaker's name, birth date, MaineCare ID number, program, referral to program, orthodontic reporting form, treatment plan, copies of bills, and all communications regarding the member.
- c. Copies of pertinent correspondence will be sent to Prevention, Health Promotion, and Optional Treatment Services for members under age twenty-one (21) in order to facilitate their coordination of services with members.

5. Reimbursement

Reimbursement for comprehensive orthodontics is not available after the member's twenty-first (21st) birthday unless treatment (placement of the brackets, extraction of teeth for orthodontic purposes or placement of orthodontic separators) has begun prior to the member's twenty-first (21st) birthday and prior authorization was granted.

- a. The all-inclusive fee covers: the acquisition and placement of major treatment appliances; the maintenance and replacement of the parts of the appliances; all bands, brackets, arch wires, ligatures, elastics, headgear, and other mass manufactured parts of all appliances indicated in the treatment plan; all retention visits indicated in the treatment plan; the initial activation of appliances; instructions to the member; all necessary member records; all other associated services and supplies, and all subsequent treatment visits.

25.03 COVERED SERVICES (cont.)

The all-inclusive reimbursement fee will be authorized in reference to the approved treatment plan and in accordance with the overall diagnosis of the case.

- b. In the event that fewer than eighteen (18) months have elapsed between the last treatment of interceptive orthodontics and the commencement of an approved comprehensive plan, then the reimbursement received for the interceptive plan will be deducted from the all-inclusive reimbursement for the comprehensive plan. In the event that eighteen (18) months or more have elapsed between the two (2) approved plans then the provider will be reimbursed independently for the comprehensive treatment plan.
- c. Providers requesting approval for comprehensive orthodontics after a period of interceptive treatment should indicate the last date of active treatment on the HLD Index Report.
- d. Additional appliance allowances are reimbursable only for custom laboratory fabricated, fixed, functional appliances that were approved as part of the treatment plan.
 - (1) The Department will reimburse the provider the adjusted acquisition cost of the appliance and an additional fee to cover the cost of the impression and bite registration materials. The provider must request reimbursement on the standard Departmental form, and submit with that request, the original laboratory invoice, or a legible photocopy, for the fabrication of the custom fixed, functional appliance.
 - (2) The provider is responsible for the first repair or replacement when a retainer is lost or broken by a member who is still within an approved retention phase of orthodontic treatment. The Department will reimburse the provider the adjusted acquisition cost of the replacement and an additional fee to cover the cost of the impression and bite registration materials for subsequent replacements.

The provider must request reimbursement on the standard Departmental form and submit with that request the original laboratory invoice, or a legible photocopy for the fabrication of the replacement retainer.

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The laboratory invoice for the fabrication of the custom fixed, functional appliance or the fabrication of the replacement retainer must include the following:

- (a) the provider's name;
- (b) the member's name;
- (c) the name or a short description of the appliance constructed (retainer);
- (d) the cost of fabrication of the appliance or retainer; and
- (e) the date of the fabrication of the appliance or retainer.

A provider who normally utilizes an "in house" laboratory for the fabrication of custom-made appliances may submit a statement of the cost of the appliance fabrication in lieu of the laboratory invoice noted above. The Department shall reimburse such providers in accordance with the prices of established orthodontic laboratories.

25.03-9 Temporomandibular Joint Services (TMJ)

Temporomandibular joint services are available for eligible members under the age of twenty-one (21) or for members of any age residing in an ICF-MR. Adult members not residing in an ICF-MR and age twenty-one (21) or older are eligible only for selected procedures as indicated in Chapter II and III of this Section, most of which are available only under the adult dental care guidelines described in Subsection 25.04.

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Temporomandibular joint (TMJ) treatment is reimbursable only by prior authorization. In addition to PA criteria set forth in this rule, the Department will require providers to use industry recognized criteria utilized by a national company under contract. Providers can access these prior authorization criteria by accessing the OMS website at: http://www.maine.gov/dhhs/oms/provider_index.html, which will have a link to the PA portal. In cases where the criteria are not met, the Provider/Member may submit additional supporting evidence such as medical documentation, to demonstrate that the requested service is medically necessary.

25.03 COVERED SERVICES (cont.)

MaineCare reimbursement will be made only in severe symptomatic cases. Prior authorization must be requested for TMJ treatment for surgical or non-surgical intervention with the exception for manipulation under anesthesia and physical therapy. The request for prior authorization must be accompanied by a comprehensive treatment plan. For treatments involving surgical intervention, a copy of the written second opinion described in Section 25.03-9(B) below must also be submitted when requesting prior authorization.

- A. Modes of non-surgical treatment include occlusal orthotic appliances, physical therapy referral, and therapeutic medication. Reimbursement for occlusal orthotic appliances include the fabrication, placement, and follow-up adjustments. The Department requires prior authorization.
- B. Treatment which involves surgical intervention, requires that a provider submit a treatment plan that includes:
 - 1. member history and documentation as to why non-surgical treatment was an unacceptable treatment option or, if already performed, did not achieve adequate results;
 - 2. the submission of transcranial films in the open, closed, and rest position or the submission of MRI studies with pathology documented by a radiologist;
 - 3. a plan of care for continued treatment (e.g., if follow-up care beyond the included thirty (30) days is required, number of visits, etc.);
 - 4. the provider's usual and customary charges; and
 - 5. a written second opinion from a surgeon. The surgeon who submits the second opinion must not have a professional financial relationship with the surgeon requesting prior authorization. The second opinion must confirm that non-surgical treatment either is not an acceptable treatment option or, if already performed, did not achieve adequate results.

25.04 COVERED SERVICES FOR ADULTS

Adult services are intended for adult members, age twenty-one (21) or older, not residing in an ICF-MR, and include only those services that can be performed in compliance with this Subsection.

25.04-1 Adult Dental Care Covered Services

Adult dental care requirements provide for adults twenty-one (21) years of age or older limited to:

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25.04 COVERED SERVICES FOR ADULTS (cont)

- A. Acute surgical care directly related to an accident where traumatic injury has occurred. This coverage will only be provided for the first three months after the accident;
- B. Oral surgical and related medical procedures not involving the dentition and gingiva;
- C. Extraction of teeth that are severely decayed and pose a serious threat of infection during a major surgical procedure of the cardiovascular system, the skeletal system or during radiation therapy for a malignant tumor;
- D. Treatment necessary to relieve pain, eliminate infection or prevent imminent tooth loss; and
- E. Other dental services, including full and partial dentures, medically necessary to correct or ameliorate an underlying medical condition, if the Department determines that the provision of those services will be cost-effective in comparison to the provision of other covered medical services for the treatment of that condition.

25.04-2 Standards of Treatment

Standards of treatment to relieve pain, eliminate infection or prevent imminent tooth loss requires the dentist to document one or more of the following in the member's record:

- A. documentation of the member's acute tooth pain or acute infection;
- B. supporting radiographs (if pertinent); or
- C. documentation of any underlying medical condition that places the member at risk of imminent tooth loss; or
- D. documentation of an accident where traumatic injury has occurred.

25.04-3 Other Adult Dental Services (Dentures)

Other adult dental services are only available for MaineCare members with qualifying medical conditions. The member's physician or MaineCare enrolled primary care provider must supply current (within the last twelve (12) months), supporting documentation of medical necessity.

Documentation must be kept in the member's file, submitted with a request for prior authorization if required, and made available upon request to the Department.

25.04 COVERED SERVICES FOR ADULTS (cont)

To qualify for full dentures under A through D of this Section, a member must be edentulous. Requests for prior authorization will be considered for dentures or other appropriate dental services only if one or more of the following criteria are met:

- A. Members with dysphagia, aspiration or other choking-risk conditions will qualify for dentures or other appropriate medically necessary dental care if:
 - 1. the condition is not amenable to, or is not suitable for corrective surgery or medical treatment;
 - 2. a swallowing study or speech therapy evaluation documenting the aspiration or choking risk is submitted; and
 - 3. the treating physician, in consultation with the member's dentist, states that their condition is most cost-effectively treated by dentures or other specified appropriate and medically necessary dental services. An example would be a recurrent esophageal stricture, not responsive to endoscopic dilations with episodes of obstruction.

- B. Members with the following medical conditions will qualify for dentures or other appropriate medically necessary dental care if the services are cost effective compared to other MaineCare covered services:
 - 1. Members who have an underlying medical condition, e.g. uncontrolled diabetes mellitus. The Department requires current documentation to substantiate that uncontrolled diabetes may be appropriately treated adjunctively with the use of dentures. Documentation must include all of the following:
 - a. HgbA1c of > eight percent (8%) on at least two (2) occasions at least six (6) months apart;
 - b. documentation of at least two (2) dietary counseling sessions with a dietician regarding an edentulous diet; and
 - c. participation in an ADEF (Ambulatory Diabetes Education and Follow-up) program within the last year, or between the two (2) HgbA1c measurements.

 - 2. Members with a medical condition causing documented, inappropriate weight loss of greater than ten percent (10%) of body weight within the last twelve (12) months or less that will be corrected or improved by the provision of medically necessary dental services, including full and partial dentures. Gastro-esophageal reflux disease (GERD), being overweight, morbidly

25.04 COVERED SERVICES FOR ADULTS (cont)

obese, or being at risk for coronary artery disease are examples of diagnoses that do not, alone, substantiate the medical necessity for dentures. Treating these conditions with dentures has not been shown to be a more effective treatment than other means.

The Department may require a trial period of other cost effective means before dentures are approved for treatment of an underlying medical condition.

- C. Members whose behavior secondary to dental pain or the psychological complications of being edentulous are causing current, severe medical or psychiatric complications, (e.g. debilitating psychiatric illness or physical harm), as documented by a licensed psychologist or psychiatrist, would qualify for necessary dental services under this Subsection.
- D. The Department may waive the criterion of being edentulous in cases where extenuating medical circumstances exist. These circumstances must clearly substantiate the medical necessity that immediate placement of dentures is necessary for the member's health due to a serious medical condition. Examples of this may be a member who is scheduled to have organ transplant surgery, chemotherapy in the near future, has had extreme (>20%) weight loss within the last twelve (12) months or less and has an underlying medical condition such as advanced HIV disease or uncontrolled Crohn's disease.
- E. Members with dentures who require replacement dentures and whose dentures are medically necessary to correct or ameliorate an underlying medical condition, and for whom the Department determines that the provision of those dentures will be cost effective in comparison to the provision of other covered medical services for the treatment of that condition.

25.05 NON-COVERED SERVICES

- A. The Department does not allow reimbursement for any member in an ICF-MR for orthodontics, orthognathic surgery, or repair of cleft palate procedures except in those cases where said treatment is being performed to correct a post-traumatic or post-surgical disfigurement, or in those cases where these services are a continuation of ongoing treatment started before age twenty-one (21).

The Department does not allow reimbursement for any member age twenty-one (21) or older for orthodontics, orthognathic surgery, or repair of cleft palate procedures except in those cases where said treatment is being performed to correct a post-traumatic or post-surgical disfigurement, or in those cases where these services are a continuation of ongoing treatment started before age twenty-one (21), or when these services meet the criteria in Special Requirements for Adult Services, 25-04-2 (B).

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- B. The Department does not allow reimbursement for missed appointments by the member. In addition, the member cannot be billed for a missed appointment even if the member was notified in advance there would be a charge.
- C. Refer to the MaineCare Benefits Manual, Chapter I and the MaineCare Benefits Manual, Section 25, Dental Services, Chapter III for additional listings of non-covered services.

25.06 POLICIES AND PROCEDURES

25.06-1 Member's Records

- A. The Department requires all providers to retain records that reflect all services billed for members, including current documentation of medical necessity, for a minimum of five (5) years and as required by Chapter I of this Manual. Dentists must maintain an office dental record for each member. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by specific dentists or hygienists rendering services.
 - 1. The record is to include the essential details of the member's health condition and of each service provided. All entries must be signed, dated, and legible.
 - 2. The dental records corresponding to all services billed to the Department must include, but shall not be limited to:
 - a. member's name and date of birth;
 - b. medical history;
 - c. pertinent findings on examination;
 - d. all radiographs and the date on which they were taken;
 - e. diagnosis of existing conditions;
 - f. written treatment plan including all treatment necessary;
 - g. date of each service;
 - h. name of person performing the service if it is other than the billing dentist;
 - i. description of all treatment;

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25.06 POLICIES AND PROCEDURES (cont)

- j. recommendations for additional treatment or consultations;
- k. medications administered or prescribed;
- l. supplies dispensed or prescribed; and
- m. tests prescribed and results.

B. Member records and any other files pertaining to services provided through this policy and reimbursed by MaineCare shall be available for review by the Division of Program Integrity.

25.06-2 The Division of Program Integrity

Please refer to Chapter I of the MaineCare Benefits Manual for the Division of Program Integrity requirements.

25.06-3 Prior Authorization of Dental Services

Prior Authorization requirements for certain services are identified in Chapter III of this Section, Allowances for Dental Services. The Department will not reimburse a provider for a specific service requiring prior authorization (PA) unless the provider has requested PA prior to performing the service. However, if there are documented emergency circumstances that make the request for prior authorization impossible, reimbursement may be granted. The Department may use, for some services, prior authorization criteria that is industry recognized criteria utilized by a national company under contract. Providers can access prior authorization criteria by utilizing the following portal: http://www.maine.gov/dhhs/oms/provider_index.html. In cases where the criteria are not met, the Provider/Member may submit additional supporting evidence such as medical documentation, to demonstrate that the requested service is medically necessary. Providers must submit prior authorization requests for dental services (other than orthodontics) on the dental claim form. The dental chart must be completed to show the entire proposed treatment plan and the original radiographs (properly mounted) must be attached to the form. The appropriate box at the top of the form must be checked and the provider's usual and customary charges included.

Eff. 8/9/10

A. Requests for prior authorization should be sent to:

MaineCare Prior Authorization Unit
Office of MaineCare Services
11 State House Station
Augusta, ME 04333-0011

25.06 POLICIES AND PROCEDURES (cont.)

- B. Approved requests for prior authorization will be returned to the provider with a prior authorization number. This number must be included in the appropriate field on the claim form when requesting reimbursement.
- C. A professional reviewer or other qualified staff will be available during regular working hours to discuss extraordinary circumstances, that might require expedited review for prior authorization.
- D. Authorizations are granted based on the member's eligibility, age, and program. Radiographs submitted in support of a request for prior authorization will be returned. Although prior authorization may have been granted, the provider is responsible for checking the member's MaineCare eligibility prior to the provision of services.

25.06-4 **Case Management**

Dental providers are responsible for case management coordination activities that lead to better oral health for members. Such activities may include, but are not limited to, sending appointment reminder notices, calling members prior to appointments, referring members to specialists or other health care providers as appropriate, and reporting member non-compliance with the treatment plan. The provider may also request member education and/or report significant missed appointments by using MaineCare Member Services' "Member Education Request Form" as needed.

25.06-5 **Qualified Professional Staff**

The Department requires all professional staff to be conditionally, temporarily, or fully licensed as documented by written evidence from the appropriate governing body. All professional staff must provide services only to the extent permitted by Qualified Professional Staff licensure and this Section of the MaineCare Benefits Manual. Services provided by the following staff are reimbursable under this Section.

- A. **Licensed Dentist:** Any person currently licensed by the Maine State Board of Dental Examiners as a Dentist as documented by written evidence from such board or licensed in accordance with the licensure of the state or province in which services are provided.
- B. **Dental Hygienist:** Any person currently licensed by the Maine State Board of Dental Examiners as a Dental Hygienist as documented by written evidence from such board or licensed in accordance with the licensure of the state or province in which services are provided. Hygienists performing services under public health supervision, including those funded by the Maine Center for Disease Control and Prevention's Oral Health Program, or supervising hygienist's services at a school of dental hygiene must be

25.06 POLICIES AND PROCEDURES (cont.)

enrolled as MaineCare servicing providers. The Department does not require dental hygienists performing services in a private dental office to enroll as servicing providers.

- C. **Denturist:** Any person currently licensed by the Maine State Board of Dental Examiners as a Denturist as documented by written evidence from such board or licensed in accordance with the licensure of the state or province in which services are provided.

25.07 REIMBURSEMENT

25.07-1 **Other Resources**

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare.

25.07-2 **Maximum Allowances**

The amount of payment for services rendered shall be the lowest of the following:

- A. the amount listed in Chapter III, Section 25, "Allowances for Dental Services;"
- B. the lowest amount allowed by Medicare; or
- C. the provider's usual and customary charge.

25.07-3 **Compliance Procedures**

Infection control, O.S.H.A. requirements and other compliance procedures are considered provider standards of care and are not billable to the member or separately reimbursable by MaineCare.

25.07-4 **Denturist Services**

In accordance with requirements of this Subsection and Subsection 25.03-6, denturist services shall be reimbursed to licensed denturists enrolled as MaineCare providers for services provided to members eligible for full dentures. Only the services related to providing full dentures will be reimbursed to denturists, using the appropriate codes (identified in the limits column) in Chapter III, Section 25 of the MaineCare Benefits Manual. These related services include making, producing, reproducing, construction, finishing, supplying, altering, or repairing of a complete upper and/or complete lower prosthetic denture.

25.07 REIMBURSEMENT (cont.)

25.07-5 **Hygienist Services**

Hygienist services shall be reimbursed to entities enrolled as MaineCare providers employing or sponsoring licensed hygienists providing hygienist services allowed under this Section and under Public Health Supervision. Services reimbursable for hygienists working under Public Health Supervision, dental hygiene schools and the Oral Health Program are designated in Chapter III, Section 25 of this Manual. These services include: prophylaxis, fluoride treatments, oral hygiene instructions and sealants. MaineCare requires entities enrolling as providers to submit documentation of satisfying the requirements for Public Health Supervision status. All hygienists enrolled under Public Health Supervision status must enroll as MaineCare servicing providers with proof of licensure. The Department will reimburse schools of dental hygiene enrolled as MaineCare providers employing supervising, licensed hygienists and providing hygienist services allowed under this Section. The supervising hygienists must be enrolled as MaineCare servicing providers.

Hygienist Services shall be reimbursed to the Maine Center for Disease Control and Prevention, Oral Health Program, enrolled as a MaineCare provider performing hygienist services through its public health, school-based and/or school-linked programs. Hygienists performing these services must enroll as MaineCare servicing providers under the Maine Center for Disease Control and Prevention, Oral Health Program, with proof of licensure, and documentation of meeting the requirements for Public Health Supervision status.

25.08 BILLING INSTRUCTIONS

Billing must be accomplished in accordance with the Department's current billing instructions. Billing instructions are available upon request or from the Department's website at: http://www.maine.gov/dhhs/bms/rules/provider_mcare_benefit.htm.

APPENDIX I

MAINECARE HANDICAPPING LABIOLINGUAL DEVIATION INDEX SCORING INSTRUCTIONS

The intent of the Handicapping Labiolingual Deviation (HLD) Index is to measure the presence or absence and the degree of the handicap caused by the components of the Index and not to diagnose "malocclusion." All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering "0" (refer to attached score sheet).

The following information helps to clarify the categories on the HLD Index Report:

Cleft Palate Deformities: Indicate an "X" on the score sheet and do not score any further if present. This condition is considered to be a handicapping malocclusion.

Deep Impinging Overbite: Indicate an "X" on the score sheet when lower incisors are destroying the soft tissue of the palate and do not score any further. This condition is considered to be a handicapping malocclusion.

Individual Anterior Teeth Crossbite: Indicate an "X" on the score sheet when destruction of soft tissue is present and do not score any further. This condition is considered to be a handicapping malocclusion.

Severe Traumatic Deviations: Traumatic deviations include loss of a premaxilla segment by burns or by accident, the result of osteomyelitis or other gross pathology. Indicate with an "X" on the score sheet, attach documentation of condition, and do not score any further. This condition is considered to be a handicapping malocclusion.

Overjet Greater than 9 mm: If the overjet is greater than 9 mm with incompetent lips or the reverse overjet (mandibular protrusion) is greater than 3.5 mm with reported masticatory and speech difficulties, indicate an "X" and score no further. If the reverse overjet is not greater than 3.5 mm, score under the "Mandibular Protrusion in Millimeters" item.

Overjet in Millimeters: This is recorded with the member's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. Round this measurement to the nearest millimeter and enter on the score sheet.

Overbite in Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. Round off to the nearest millimeter and enter on the score sheet. "Reverse" overbite may exist in certain conditions and should be measured and recorded.

Mandibular Protrusion in Millimeters: Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. The measurement in millimeters is entered on the score sheet and multiplied by five (5). A reverse overbite, if present, should be shown under "overbite."

Open Bite in Millimeters: This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge in millimeters. Enter the measurement on the score sheet and multiply by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

Ectopic Eruption: Count each tooth, excluding third molars. Enter the number of teeth on the score sheet and multiply by three (3). If anterior crowding is present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.

Anterior Crowding: Arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter five (5) points each for maxillary and mandibular anterior crowding. If ectopic eruption is also present in the anterior portion of the mouth, score the most severe condition. Do not score both conditions.

Labiolingual Spread: Use a Boley Gauge or a disposable ruler to determine the extent of deviation from a formal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be

made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labiolingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labiolingual spread, but only the most severe individual measurement should be entered on the index.

Posterior Unilateral Crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal and completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet.

APPENDIX II

MaineCare - Handicapping Labiolingual Deviation (HLD) Index Report

Provider Name: _____ Provider MaineCare #: _____

Member Name: _____ Member MaineCare ID #: _____ Member DOB: _____

Has this member received ortho treatment previously? ___ Yes ___ No If yes, name of provider: _____

If yes, was this member transferred from this previous provider? ___ Yes ___ No Date of Last Tx, if known: _____

Instructions: (Assistance from a recorder/hygienist is recommended).

1. Position the member's teeth in centric occlusion.
2. Record all measurements in the order given and round to the nearest millimeter (mm).
3. ENTER A SCORE OF "0" IF A CONDITION IS ABSENT,
4. Enter the requested provider and member information above. Provider must sign and date at the bottom.

Condition	HLD Score
Cleft palate deformities (<i>Indicate an "X" if present and score no further</i>).	
Deep impinging overbite WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE (<i>Indicate an "X" if present and score no further</i>).	
Individual anterior teeth crossbite WHEN DESTRUCTION OF SOFT TISSUE IS PRESENT (<i>Indicate an "X" if present and score no further</i>).	
Attach description of any severe traumatic deviations. For example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. (<i>Indicate an "X" if present and score no further</i>).	
Overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5 mm with reported masticatory/speech difficulties. (<i>Indicate an "X" if present and score no further</i>).	
Overjet in mm.	
Overbite in mm.	
Mandibular protrusion in mm.	_____ x 5 = _____
Open bite in mm.	_____ x 4 = _____
If both anterior crowding and ectopic eruption are present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.	
Ectopic eruption: Count each tooth, excluding 3 rd molar.	_____ x 3 = _____
Anterior crowding: Score one point for MAXILLA, and/or one point for MANDIBLE; two points maximum for anterior crowding.	_____ x 5 = _____
Labiolingual spread in mm.	
If the member has a posterior unilateral crossbite; involving two or more adjacent teeth, one of which is a molar, enter/score a "4" for this item.	
TOTAL SCORE:	

If a member does not score an HLD Index of 26 or above, are there other conditions such as impacted canines (include panoramic film), occlusal interferences, functional jaw limitations, facial asymmetry, speech impairment, or other physical deviations? If yes, please describe and include any supporting documentation.

Are there any indications of potential impairment of mood and/or conduct that may result from emotional distress related to the malocclusion? If yes, please describe and include any supporting documentation.

Provider Signature: _____ Date: _____