Prior Authorization for Interceptive Orthodontic Treatment

MassHealth approves prior authorization (PA) requests for interceptive orthodontic treatment if such treatment will prevent or minimize the development of a handicapping malocclusion or preclude the need for comprehensive orthodontic treatment. 130 CMR 420.431(B)(2). The process for requesting PA for interceptive orthodontic treatment is described below:

(A) Provider performs pre-orthodontic treatment examination (130 CMR 420.431(C)(1)) to determine if orthodontic treatment is necessary.

(B) Provider completes and submits the following:

(1) 2012 ADA Claim form requesting authorization for interceptive orthodontic treatment. The form must include:
   (a) the code for the appliance requested (D8050 or D8060); and
   (b) the code (D8999) for requested adjustments visits; and
   (c) the number of adjustment visits requested, not to exceed five (5).

(2) **Supporting documentation**. Providers ***must*** submit:

a) a medical necessity narrative explaining why, in the professional judgment of the requesting provider and any other involved clinician(s), interceptive orthodontic treatment is medically necessary to prevent or minimize the development of a handicapping malocclusion or will preclude the need for comprehensive orthodontic treatment. The medical necessity narrative must clearly demonstrate why interceptive orthodontic treatment is medically necessary for the patient.

If any part of the requesting provider's justification of medical necessity involves a mental, emotional, or behavioral condition; a nutritional deficiency; a speech or language pathology; or the presence of any other condition that would typically require the diagnosis, opinion, or expertise of a licensed clinician other than the requesting provider, then the medical necessity narrative and any attached documentation must:

i. clearly identify the appropriately qualified and licensed clinician(s) who furnished the diagnosis or opinion substantiating the condition or pathology (e.g., general dentist, oral surgeon, physician, clinical psychologist, clinical dietitian, speech therapist);
ii. describe the nature and extent of the identified clinician(s) involvement and interaction with the patient, including dates of treatment;
iii. state the specific diagnosis or other opinion of the patient's condition furnished by the identified clinician(s);
iv. document the recommendation by the clinician(s) to seek orthodontic evaluation or treatment (if such a recommendation was made);
v. discuss any treatments for the patient's condition (other than interceptive orthodontic treatment) considered or attempted by the clinician(s); and
vi. provide any other relevant information from the clinician(s) that supports the requesting provider's justification of the medical necessity of interceptive orthodontic treatment.

The medical necessity narrative must be signed and dated by the requesting provider and submitted on the office letterhead of the provider. If applicable, any supporting documentation from the other involved clinician(s) must also be signed and dated by such clinician(s), and appear on office letterhead of such clinician(s). The requesting provider is responsible for coordinating with the other involved clinician(s) and is responsible for

compiling and submitting any supporting documentation furnished by other involved clinician(s) along with the medical necessity narrative.

b) The following is a non-exclusive list of medical conditions that may, if documented, be considered in support of a request for PA for interceptive orthodontics:

i. Two or more teeth numbers 6 through 11 in crossbite with photographic evidence documenting 100% of the incisal edge in complete overlap with opposing tooth/teeth;
ii. Crossbite of teeth numbers 3, 14 or 19,30 with photographic evidence documenting cusp overlap completely in fossa, or completely buccal-lingual of opposing tooth;
iii. Crossbite of teeth number A,T or J, K with photographic evidence documenting cusp overlap completely in fossa, or completely buccal or lingual of opposing tooth;
iv. Crowding with radiographic evidence documenting current bony impaction of teeth numbers 6 through 11 or teeth numbers 22 through 27 that requires either serial extraction(s) or surgical exposure and guidance for the impacted tooth to erupt into the arch;
v. Crowding with radiographic evidence documenting resorption of 25% of the root of an adjacent permanent tooth.
vi. Class III malocclusion, as defined by mandibular protrusion of greater than 3.5mm, anterior crossbite of more than 1 tooth/ reverse overjet, or Class III skeletal discrepancy, or hypoplastic maxilla with compensated incisors requiring treatment at an early age with protraction facemask, reverse pull headgear, or other appropriate device.

(3) imaging evidencing the existence of the condition(s) noted in the medical necessity narrative.

(4) a completed Appendix F attestation (found on page F-3 of Appendix F).

Attestation

MassHealth Dental Prior Authorization Request for Interceptive Orthodontics

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Patient's Name (please print) _____ Member ID_____

Address _____
Street City/County State Zip Code

I certify under the pains and penalties of perjury that I am the prescribing provider identified on this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on the information provided is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature:

_____
(Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Printed name of prescribing provider _____ Date _____

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