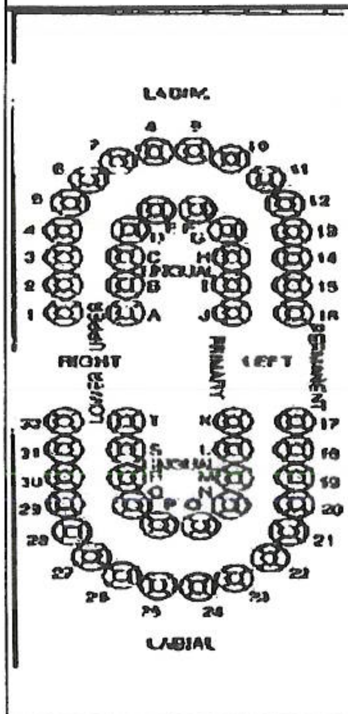
**NEW YORK STATE DEPARTMENT OF HEALTH**
**BUREAU OF DENTAL HEALTH**

**REQUEST FOR PRIOR APPROVAL OF ORTHODONTIC AND ORTHODONTIA-RELATED SERVICES**
**PHCP DENTAL REHABILITATION PROGRAM**

| Recipient Name | Date of Birth | Recipient ID Number | Sex M F | Age (under 21) ☐ | County of Residence |
|---|---|---|---|---|---|
| Recipient Address: No. Street City Zip | | Recipient Phone Number | Parent/Guardian | | |
| Referring Provider Name | MA Provider ID No | Provider Address | | Provider Phone Number | Fax Number |




**Assessment:**
*Please check which of the following eligible conditions apply:*

The child exhibits a severe physically handicapping malocclusion which affect oral health, function and esthetics, as defined below:

- ☐ overjet of 6 mm. or more;
- ☐ overbite of 10 mm. or more and/or lower anteriors contact palatal tissue;
- ☐ open bite of 5 mm. or more;
- ☐ centric occlusion where it is difficult to replicate centric and/or where there is pseudo-crossbite (mandibular functional shift);
- ☐ severe crowding of maxillary anteriors;
- ☐ anterior crossbite due to prognathism; or
- ☐ blocked out maxillary cuspids that threaten the integrity of the anterior section of the arches;
- ☐ cleft lip and/or palate;
- ☐ severe dysplasia;
- ☐ deviations resulting from disease or trauma to either jaw;
- ☐ other qualifying congenital anomalies:
  - ☐ mandibular micrognathia;
  - ☐ maxillary prognathism;
  - ☐ extreme madibular prognathism;
  - ☐ ankylosis;
  - ☐ other severe dental conditions resulting in speech defect.

Other – *Specify:*

Are required panorex or cehphalometric x-rays included? ☐ Yes ☐ No
Are pictures of models included? ☐ Yes ☐ No
Are intraoral photographs included? ☐ Yes ☐ No

Dentition: ☐ Permanent ☐ Late mixed ☐ Primary

*Please note: If late mixed, mixed or primary dentition, child is eligible only with cleft lip, cleft palate, severe dysplasias or other qualifying congenital anomalies.*

Is this a request for initial placement of appliance? ☐ Yes ☐ No
*If no, please provide date initially placed:*

Are additional dental services needed *in connection with* orthodontia?

- ☐ Extractions
- ☐ Restoration
- ☐ Prophylaxis
- ☐ Fluoride application
- ☐ Prosthetics
- ☐ Oral and maxillo-facial surgery
- ☐ Consultation

*Indicate needed procedures on Examination and Treatment Plan below.*

Signature of Requesting Provider: Date:

***Action Codes** (to be added by reviewer): **1** - Approved; **2** – Approved, as specified; **3** – Denied, non-covered service; **4** – Denied, insufficient information; **5** – Denied, as specified.

**Examination and First Year Treatment Plan:** *Note:* Prior Approval does not guarantee payment, which is subject to child's continued financial eligibility for the program.

| *Provider to fill in:* | | | | | | | *Office Use Only:* | | | | *Practitioner: Initial when work is completed* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Procedure Code | Tooth# | Surface | Description | Times Requested | Amount Requested | **Action Code*** | Times Approved | Excess Pay | Amt. Approved | |
| 1 | | | | | | | | | | | |
| 2 | | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 5 | | | | | | | | | | | |

Reviewer's Comments:

| Review Date: | Approved Period of service: From: / / to / / | Reviewer Name: | Signature: |
|---|---|---|---|

**Progress Report:** *To be submitted after each year of active treatment or at case conclusion. If requesting an additional period of service, attach new request and treatment plan.*

| Years of care completed: ☐ 1 ☐ 2 ☐ 3 ☐ 4 | Type of appliance used: | No. patient visits during this time: | No. of missed visits: |
|---|---|---|---|
| Summary of treatment: | | Further care needed: ☐ Active ☐ Retention | No further care needed: ☐ |
| | | Provider Signature: | Date: |

DOH – 4268 (9/04)

**PHCP DENTAL REHABILITATION PROGRAM**
**PROCEDURES AND CODES**

**Procedure for obtaining prior approval:** 1. Children treated under this program must be *both financially* and *clinically* eligible to participate.

2. The child must have been found financially eligible for the Physically Handicapped Children's Program (PHCP) by the county of residence.
3. The county of residence must participate in the Dental Rehabilitation portion of PHCP and be willing to cover orthodontic services for eligible children.
4. The initial screening for clinical eligibility and the request for prior approval may be done by any qualified provider currently enrolled with the PHCP program.
5. The provider indicates on the front of this form which qualifying conditions apply and which procedures are needed.
6. The provider then submits this Request For Prior Approval to the Physically Handicapped Children's Dental Rehabilitation Program.

| ***For children with PHCP***, submit this Request For Prior Approval to: | ***This form relates only to prior approval under the Physically Handicapped Children's Program (PHCP).*** *For children with Medicaid, submit requests for prior approval on Form DSS-3614 to:* |
|---|---|
| New York State Department of Health<br>Bureau of Dental Health<br>Room 542, Corning Tower, ESP<br>Albany NY 12237- 0619 | New York State Department of Health<br>Bureau of Medical Review and Payment - Dental Prior Approval Unit<br>150 Broadway, Suite 6E<br>Albany NY 12204-2736 |

7. Approval or denial will be sent back to the examining orthodontist and copied to the county PHCP.
8. Providers may bill when authorized care is completed (appliance is installed) by initialing the front of the form and returning it to the PHCP in the child's county of residence.

**Annual Reauthorization:** Care needs to be reauthorized annually using this same form. It is recommended that copies of authorizations from the previous year be copied and appended. Providers must provide a progress report at the time of reauthorization.

**Billing Codes:** Medicaid billing codes are used for both the MA and PHC Programs. Common codes are listed below. Refer to the MA Fee Schedule for complete information.
*If billing only for screening to determine program eligibility, please bill as Pre-Orthodontic Treatment Exam (08660).*

| **Radiographs Imaging** | **Bill Code** | **Fee** |
|---|---|---|
| Panoramic film | D0330 | $40.00 |
| Cephalometric film | D0340 | $58.00 |
| Intraoral; complete series (including bitewings) | D0210 | $58.00 |
| **Preventive Procedures** | **Bill Code** | **Fee** |
| Prophylaxis (13 y/o & older) | D1110 | $58.00 |
| Prophylaxis (Under age 13) | D1120 | $43.00 |
| Topical Fluoride Treatment – Prophy not included/< age 21 | D1203 | $14.00 |
| **Space Maintenance - Passive** | **Bill Code** | **Fee** |
| Space Maintainer–fixed unilateral (quad) | D1510 | $116.00 |
| Space Maintainer–fixed bilateral (arch) | D1515 | $174.00 |
| Re-cementation of space maintainer | D1550 | $21.00 |
| **Pre-Orthodontic Treatment visit-** not billed with 01120 | D8660 | $29.00 |
| **Consultation**–provider other than one providing treatment | D9310 | $87.00 |
| **Unspecified orthodontic procedures** – Observation only | D8999 | $120.00 |
| **Extractions – includes local anesthesia, suturing, if needed, and routine post-operative care** | **Bill Code** | **Fee** |
| Surgical exposure of unerupted tooth for orthodontic reasons, including orthodontic attachments, with 14 follow-up days | D7281 | $290.00 |
| Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth, with 10 follow-up days | D7210 | $90.00 |
| Surgical removal of residual root (cutting), with 10 f/up days | D7250 | $58.00 |

| **Interceptive Orthodontic treatment:** | **Bill Code** | **Fee** |
|---|---|---|
| Primary Dentition - rapid palatal expansion - fixed appliance only | D8050 | By Report |
| Transitional Dentition – rapid palatal expansion - fixed appliance only | D8060 | By Report |
| **Removable Appliance Therapy** | D8210 | By Report |
| **Orthodontic Treatment, active, comprehensive:** | **Bill Code** | **Fee** |
| Comprehensive orthodontic treatment of the transitional dentition. Bill $986 (initial payment for approved course of orthodontia) when appliance placed, then $232 after every quarter of active treatment up to 12 quarters with annual approval. | D8070<br>D8670 | $986.00<br>$232/Q. |
| Comprehensive orthodontic treatment of adolescent dentition. Bill $986 (initial payment for approved course of orthodontia) when appliance placed, then $232 after every quarter of active treatment up to 12 quarters with annual approval. | D8080<br>D8670 | $986.00<br>$232/Q. |
| Comprehensive orthodontic treatment of adult dentition, < age 21. Bill $986 (initial payment for approved course of orthodontia) when appliance placed, then $232 after every quarter of active treatment up to 12 quarters with annual approval. | D8090<br>D8670 | $986.00<br>$232/Q. |
| **Retention Services** | **Bill Code** | **Fee** |
| Orthodontic retention-removal of appliance, construct & place retainer | D8680 | $174.00 |
| Replacement of lost or broken retainer | D8692 | $145.00 |

**Provider Responsibilities:** Referring dentists and orthodontists are responsible for performing and documenting the initial clinical assessment, mailing in the Prior Approval form to the appropriate program, ascertaining that the child is enrolled in the program being billed, and performing authorized work on enrolled children.