Iowa Medicaid
Iowa HHS

Policy Clarification #PC000267
Hawki Orthodontia Coverage

July 22, 2025

To: Iowa Medicaid Managed Care Plans

This letter is a formal notification of the Department's expectations related to the operations and implementation of Iowa Medicaid under the managed care program.

Purpose of this communication (check all that apply):

☒ Provide formal guidance
☐ Clarification of existing Iowa Medicaid policy
    Federal mandate: [cite CFR]
    Iowa Code: [cite section]
    Iowa Administrative Code: [cite IAC]
    Managed Care Contract: [cite contract section and if MCO or PAHP]
☐ Guidance on new process or policy
☐ Request for information
    IT System clarification revision to previous Policy Clarification: [cite PC#]

The purpose of this letter is to provide clarification on qualifications of Orthodontia coverage for Hawki members based on Medical Necessity.

The contractor shall cover medically necessary orthodontia services which are outlined below. This will be in effect from July 1, 2025, through September 30, 2025. On October 1, 2025, new medically necessary orthodontia coverage will be in place and will void this policy clarification.

Medically Necessary Orthodontic Services - an orthodontic procedure that addresses a harmful habit, is an anatomical qualifying clinical condition, or is a limited, interceptive, or comprehensive orthodontic procedures that treats a handicapping malocclusion with a Salzmann score of 26 or greater.

Orthodontic Coverage

Orthodontic procedures require prior authorization and will be approved when "medically necessary" as defined below. A "handicapping" malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:

- Impaired mastication,
- Dysfunction of the temporomandibular articulation
- Susceptibility to periodontal disease,
- Susceptibility to dental caries, and
- Impaired speech due to malposition of the teeth.

Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables: degree of mal-alignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite. A Salzmann Index score of 26 or greater will be used as criteria for "medically necessary" orthodontic benefits.

Approval for treatment will be assessed in a manner consistent with "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, DDS, American Journal of Orthodontics, October 1968. Approval may be made for a complete comprehensive case of active orthodontic treatment.

Provider's request for prior authorization shall be accompanied by:

• An interpreted cephalometric radiograph (either a full series of radiographs or panograph film).
• Study models trimmed so that the models simulate centric occlusion of the recipient when the models are placed on their heels.
• A written plan of treatment.

*Post treatment records or a randomized record audit may be requested.

MINOR TREATMENT TO CONTROL HARMFUL HABITS

D8210 Removable appliance therapy. Requires prior authorization.
D8220 Fixed appliance therapy. Requires prior authorization.

*These procedures will be approved for a finger, lip, or tongue habit that has deformative impact on the teeth and/or jaw structures. Requests for approval shall be accompanied by documentation of the nature and scope of the deleterious habit.

Orthodontic Records (for use with limited and comprehensive treatments):
D8660 Pre-Orthodontic Examination to monitor growth and development ($200.00) (maximum allowed amount for approved ortho is $4,300. The $200.00 will be deducted if D8080 is approved)
*Use this procedure code for diagnostic procedures (radiographs, films, photos, casts, etc.

LIMITED OR INTERCEPTIVE TREATMENT

The following procedure code may be billed for orthodontic treatment with a limited objective, not necessarily involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. A palatal expander can be billed under this CDT code and if applicable a D8680 can be billed for the removal and retention at the completion of the expansion.

D8020 Limited orthodontic treatment of the transitional dentition

COMPREHENSIVE ORTHODONTIC TREATMENT OF PERMANENT DENTITION

D8070 I D8080 I D8680 I D8999

These procedures require prior authorization. Orthodontic procedures will be approved for handicapping malocclusions that meet a Salzmann Index score of 26 or greater. The request for prior authorization shall be accompanied by:

- An interpreted cephalometric radiograph (either a full series of radiographs or pantograph film),
- Study models trimmed so that the models simulate centric occlusion of the recipient when the models are placed on their heels, and
- A written plan of treatment.

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Related to this Policy Clarification:

- Effective Date of this Policy Clarification: July 1, 2025
- Claims processing requirement:
  - ☐ Prospective
  - ☒ Retroactive
  - ☐ Not applicable

Attestation:

I hereby acknowledge receipt and understanding of this policy clarification, including all specified requirements and deadlines.

Name_____ Date_____

The department will monitor progress towards implementation and may impose remedies for failure to implement.

Sincerely,

Ashley Miller

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