FACT SHEET:
MEDICAID COVERAGE OF ORTHODONTIA FOR CHILDREN[*]

Prepared by:
Manjusha P. Kulkarni
National Health Law Program
March 2005

Medicaid, EPSDT and Dental Care

The Medicaid program, found in Title XIX of the Social Security Act, is a cooperative state and federal program that covers health care for categories of low-income individuals.[1] States have the option of covering dental services for adults through Medicaid.[2] Medicaid requires, however, that all beneficiaries under the age of 21 receive Early and Periodic, Screening, Diagnostic and Treatment (EPSDT).[3] EPSDT consists of screening, diagnostic and treatment services.[4] In the dental context, children are entitled to dental examinations, as well as

---

[*] Produced by the National Health Law Program with a grant from the Training Advocacy Support Center (TASC) at the National Association of Protection and Advocacy Systems, Inc. Support for the development of this document comes from a federal interagency contract with the Administration on Developmental Disability (ADD), the Center for Mental Health Services (CMHS), and the Rehabilitation Services Administration (RSA). Assistance with this fact sheet provided by Randi Mezzy of Connecticut Legal Services was invaluable.

[1] *See* 42 U.S.C. § 1396 *et seq*.

[2] *See* 42 U.S.C. § 1396d(a)(10) ; 42 C.F.R.§ 440.100. *See also* CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE MEDICAID MANUAL § 4430; CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ORAL HEALTH: MEDICAID DENTAL COVERAGE (*available at* http://www.cms.hhs.gov/oralhealth/1.asp).

[3] *See* 42 U.S.C. §§ 1396a(a)(43), d(a)(4)(B); 42 C.F.R. § 440.40(b). While State participation is voluntary, once a State elects to participate, it "must comply with the requirements imposed both by the Act itself and by the Secretary of Health and Human Services. Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981). *See also* Wilder et al. V. Virginia Hospital Ass'n, 496 U.S. 498, 500 (1990). EPSDT is a mandatory service required of all states participating in the Medicaid program. 42 U.S.C. §§ 1396a(a)(10), d(a)(4)(B).

[4] 42 U.S.C. § 1396d(r); 42 C.F.R. § 441.56. *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE MEDICAID MANUAL § 5124.

diagnosis and treatment of dental conditions, such as dental caries, periodontal disease and malocclusion.

Before authorizing treatment under Medicaid, states determine if medical or dental care is medically necessary. The Medicaid Act requires that EPSDT dental services "shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health."[5] Furthermore, the Act explicitly mandates that states provide "such other necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."[6] While the Medicaid Act, accompanying regulations and federal guidance provide a great deal of instruction on what services must be covered, states have some flexibility in developing processes to determine whether orthodontia services are medically necessary.

Malocclusion and Orthodontia

Orthodontia is a dental service provided to children and adults with malocclusion, or poor alignment of teeth. Malocclusion can be caused by any number of conditions, including crowding of teeth, overjet, overbite or crossbite.[7] It can be inherited or brought on by premature tooth loss, thumb sucking and pacifier use; malocclusion can also develop as children grow older.[8] If the malocclusion is severe, children may have difficulty biting and chewing, swallowing, and speaking.[9] Additionally, dental-facial impairments may cause psychological damage, with children refusing to interact with peers, withdrawing socially and generally suffering from low self-esteem; if the impairment is extreme, the malocclusion can be considered

---

[5] 42 U.S.C. § 1396d(r)(3); 42 C.F.R. § 441.56(c)(2). *See also* CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE MEDICAID MANUAL § 5124B.2.b. According to Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid, those services may not be limited to emergency services for EPSDT recipients. *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OFLTH AND HUMAN SERVICES, ORAL HEALTH: MEDICAID DENTAL COVERAGE (*available at* http://www.cms.hhs.gov/oralhealth/1.asp).

[6] *See* 42 U.S.C. § 1396d(r)(5); 42 C.F.R. § 440.40(b)(2).

[7] American Association of Orthodontists, Facts About Orthodontics (2005)(*available at* http://www.braces.org/braces/about/faq/faq_background.cfm).

[8] CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, A GUIDE TO CHILDREN'S DENTAL CARE IN MEDICAID, app. 14 (October 2004) (*available at* http://www.cms.hhs.gov/medicaid/epsdt/dentalguide.pdf).

[9] *Id.*

"handicapping."[10]

While orthodontists frequently provide orthodontia to treat any type of malocclusion in the private market, in the Medicaid context, orthodontia is generally considered to be medically necessary only when children exhibit handicapping malocclusion.[11] The State Medicaid Manual by Centers for Medicare and Medicaid Services, which administers the Medicaid program, states, "Therapeutic Services include . . . [o]rthodontic treatment when medically necessary to correct handicapping malocclusion."[12] However, the *Guide to Children's Dental Care in Medicaid*, published by CMS in October 2004, explains that among the dental services to be provided is "orthodontic treatment when medically necessary to correct handicapping and other malocclusions."[13]

Screening Tools to Authorize Medicaid Coverage of Orthodontia

To determine whether orthodontia services should be covered by Medicaid, states have relied upon occlusal indices which record the existence of a malocclusion and measure its degree

---

[10] *Id.*

[11] While the American Association of Orthodontists (AAO) initially adopted the Salzmann index as the tool for determining whether orthodontia was medically necessary treatment for handicapping malocclusion, the Association formally rescinded the action in 1985 and declared that it opposed use of any index measuring malocclusion to identify treatment needs of patients, stating that it did "not recognize any index rating classification or coding system as a scientifically valid measure of the need for orthodontic treatment." William S. Parker, D.M.D., Ph.D., *The HLD (CalMod) Index and the Index Question*, 114 AMERICAN JOURNAL OF ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS 134, 135 (August 1998); Heekyung Han, D.D.S., M.S., and William M. Davidson, D.M.D., Ph.D., *A Useful Insight into 2 Occlusal indexes: HLD (Md) and HLD (CalMod)*, 120 AMERICAN JOURNAL OF ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS 247 (September 2001)(quoting the Fall 1990 AAO Bulletin).

[12] *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, STATE MEDICAID MANUAL § 5124B.b.

[13] *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 8, at 12. According to the Guide, "[p]rimary pediatric oral health care is best delivered in a 'dental home' where competent oral health care practitioners provide continuous and comprehensive services . . . . An adequate dental home should be expected to provide children and their parents with . . . interceptive orthodontic care for children with developing malocclusions." *See id.* at 5. Furthermore, it states that orthodontic treatment can be preventive, interceptive or comprehensive. *See id.* at app. 14.

or severity.[14] These indices can take direct physical measurements, recognizing discrete variations, or record dental attractiveness by considering malocclusion as a whole.[15] While states have utilized various screening indices, the two most common are the Handicapping Labio-Lingual Deviation (HLD) index and the Salzmann index.[16] The HLD index scores and weighs selected deviations from an ideal occlusion and the Salzmann index measures variations from an arbitrary standard of occlusion.[17] In both indices, points are given for various conditions that are present in the child's mouth and numerical scores are assigned based upon the degree or severity of the conditions.

While several states currently use the Salzmann index or the HLD index, neither is without its problems. A number of states use the Salzmann index in their authorization processes, although it was actually never intended to indicate medical necessity. Rather, the purpose of the index, according to its creator Dr. Salzmann, was to provide a method for establishing which patients and conditions receive priority in consideration of available professional personnel and budgetary limitations in a community.[18] While budgetary limitations may influence services provided in state and local non-entitlement public health programs, they

---

[14] Malcolm L. Jones, WALTHER AND HOUSTON'S ORTHODONTIC NOTES 237 (2000). An occlusal index may be used to "record the various deviant occlusal traits of a malocclusion in either numerical or categorical form."

[15] *Id.*

[16] Other commonly used indices include the Index of Orthodontic Treatment Need (IOTN), the Grainger Orthodontic Treatment Priority Index and the Peer Assessment Rating (PAR) index. For more information on these indices, *see* John W. Younis *et al.*, *A Validation Study of Three Indexes of Orthodontic Treatment Need in the United States*, 25 COMMUNITY DENTISTRY AND ORAL EPIDEMIOLOGY 358-62 (1997); William S. Parker, D.M.D., Ph.D., *supra* note 11, at 134-35.

[17] William S. Parker, D.M.D., Ph.D., *supra* note 11, at 136.

[18] J.A. Salzmann, D.D.S, F.A.P.H.A., ORTHODONTICS IN DAILY PRACTICE 628-29 (1974). While Dr. Salzmann stressed the importance public health epidemiologic purposes of differentiating between handicapping and non-handicapping malocclusion to establish treatment priorities, he explained that handicapping malocclusion in one individual may not be handicapping in another. He further stated that some malocclusions determined to be handicapping in a patient may not be considered such by the patient herself while others believed to be non-handicapping may have a huge impact on the patient's social interactions and may even impede her achievement potential. "Such patients," he said, "should be treated in prepaid and public health orthodontic programs even if they do not fit the established categories for accepting patients."

cannot be a consideration in the provision of EPSDT services.[19] The HLD index has other problems. Several states utilize the HLD index, but their measuring processes and standards vary. For example, California and Maryland both use the HLD index, but children in California must obtain a score of 26 for Medicaid coverage of orthodontia while children in Maryland only need a score of 15.[20] Scoring varies between the two indices, with the California index adding points for overjet and overbite and the Maryland index subtracting points for those two conditions; this potentially means that Medicaid-enrolled children in California must demonstrate a greater degree of malocclusion to receive orthodontic treatment than similar children in Maryland.[21] In fact, a study reviewing 313 patients' dental records found that 127, or 41%, would have received a qualifying score of 15 points using the Maryland index while only 110, or 35%, would have received a necessary score of 26 points or more using the California index.[22] Moreover, California's HLD index weighs heavily in favor of a certain class of malocclusion, known as Class II, while Maryland's index weighs Class I and II malocclusions equally.[23] Such variations likely result in inconsistent determinations regarding the authorization of orthodontia along state lines.

The lack of precision as well as the arbitrariness of the standards in occlusal indices generally can lead to inconsistent findings. They can also result in failure of the indices to detect

---

[19] *See* Jackson v. Millstone, 801 A.2d 1034, 1049 (Md. 2002). The Court stated

> The federal program makes no mention of utilizing an "appropriateness" analysis in determining whether a medicaid-eligible child should receive medically necessary treatments provided through EPSDT services. . . . The federal guidelines allow states no discretion to use an "appropriateness" test in deciding whether a person under 21 can receive medically necessary treatment.

Id. The Jackson court defined "appropriate" as "an effective service that can be provided, taking into consideration the particular circumstances of the recipient and the relative cost of any alternative services which could be used for the same purpose." *See id.* at 1047.

[20] Heekyung Han, D.D.S., M.S., and William M. Davidson, D.M.D., Ph.D., *A Useful Insight into 2 Occlusal indexes: HLD (Md) and HLD (CalMod)*, 120 AMERICAN JOURNAL OF ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS 247, 248, 251 (September 2001).

[21] *See id.* at 249.

[22] *See id.* at 250. Additional information on scoring on the two indices can be found in the article.

[23] *Id.* at 252.

the existence of handicapping malocclusion.[24] This is true even in cases where the child's impairment and deformities are extreme or severe. For that reason, CMS' *Guide to Children's Dental Care in Medicaid* advised:

> In spite of the general utility of these screening tools, Medicaid program directors are encouraged to utilize dentists trained and experienced in pediatric orthodontic and dental-facial orthopedic care to develop and implement orthodontic treatment criteria that can be applied reliably and consistently.[25]

Several courts came to a similar conclusion in reviewing the issue of Medicaid coverage of orthodontia, as described in the upcoming case law section.

Case Law Support for Medicaid Coverage of Orthodontia

Over the past thirty years, courts have repeatedly invalidated state attempts to deny Medicaid coverage of orthodontia to children. The first case to examine this issue, *Brooks v. Smith*, held that Maine's rules and regulations did not bar the Department of Health and Welfare from providing funds for orthodontia to maintain the general health of a Medicaid-enrolled child and avoid irreversible damage to her teeth.[26] In its decision, the Maine Supreme Court stated, "The State's authority to impose 'utilization control' permits it to determine what use is to be made of private professional services . . . [but it is not] a grant of authority by the Secretary to make available less treatment than that mandated by the federal regulation. . . ."[27] In *Philadelphia Welfare Rights Organization v. Shapp*, the Third Circuit found that orthodontic services were required to be provided under Pennsylvania's EPSDT program even though they were not part of the state's medical assistance program.[28] Similarly, in *Persico v. Maher*, the Connecticut Supreme Court determined that Connecticut's policy of denying orthodontia services except when necessary to alleviate a serious health problem did not comply with federal

---

[24] *See* J.A. Salzmann, D.D.S, F.A.P.H.A., *supra* note 18 at 629 (stating "the handicapping effect of some malocclusions in children is not always immediately recognizable except in gross dentofacial deviations.").

[25] *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 8, at app. 15.

[26] *See* Brooks v. Smith, 356 A.2d 723 (Me. 1976).

[27] *Id.* at 728.

[28] *See* Philadelphia Welfare Rights Organization v. Shapp, 602 F.2d 1114 (3d Cir. 1979) *cert. denied sub. nom.* Thornburgh v. Philadelphia Welfare Rights Organization, 444 U.S. 1026 (1980).

Medicaid regulations pertaining to EPSDT.[29] The Court also found that although orthodontia was not specifically mentioned in the federal EPSDT regulations, it was included in "'treatment *necessary* for the maintenance of . . . dental health.'"[30]

In more recent cases, courts have held that bright-line tests to determine eligibility for orthodontic care violate Medicaid mandates and instead emphasized the need for individualized review. In *Chappell v. Bradley*, the U.S. District Court denied a motion for summary judgment, finding that there was a genuine issue of material fact regarding what standard the Illinois Department of Public Aid (IDPA) used to determine Medicaid coverage of orthodontia and whether that standard violated the Medicaid Act.[31] At the time, Illinois limited the provision of orthodontic services to Medicaid-enrolled children with "severe handicapping malocclusion" and required prior approval. Delta Dental Plan, Illinois' administrative vendor, granted approval to categorically needy children through age 20 who scored 42 or higher on the Salzmann Handicapping Malocclusion Assessment Record Index (Salzmann index).[32] The Court found that both the contract between Delta Dental and IDPA and the Delta Dental provider manual established a bright line rule violating the Medicaid requirement that states provide medically necessary care to children through EPSDT.[33]

In the Court's discussion of the facts, it was revealed that IDPA had raised the score needed to obtain approval for orthodontia three times.[34] When Illinois began using the Salzmann

---

[29] *See* Persico v. Maher, 465 A.2d 308 (Conn. 1983).

[30] *Id.* at 314-315 (citing *Brooks v. Smith*, 356 A.2d 723 (Me. 1976)).

[31] *See* Chappell v. Bradley, 834 F. Supp. 1030 (N.D. Ill. 1993).

[32] *Id.* at 1032.

[33] *See id.* at 1032, 1034. In its November 24, 1993, Memorandum Opinion and Order, the Court provided this clarification,

> To comply with federal law the IDPA must authorize orthodontic treatment to all eligible patients having handicapping malocclusions severe enough to have a medical need for such orthodontic treatment. The IDPA need not provide orthodontic care to eligible patients having handicapping malocclusions if such conditions are not severe enough to have a medical need for such orthodontic treatment.

Chappell v. Bradley, 1993 WL 496700 (N.D. Ill. 1993) (eliminating the adjective "severe" in describing the handicapping malocclusion for which IDPA must provide payment).

[34] *See id.* at 1034.

index in 1981, the cut-off point was 30.[35] That number increased to 35 in 1982 and to 40 in 1983.[36] It was raised again in 1988 to 42, the score needed when plaintiffs brought the lawsuit.[37] The Director of IDPA admitted that the increase was due primarily to monetary reasons and led to fewer children being approved for treatment.[38] Additionally, one of Delta Dental's orthodontic experts acknowledged that a score of 42 did not always correspond to a finding of severely handicapping malocclusion, Illinois' supposed standard for granting authorization for orthodontic services.[39] On the other hand, he noted, a child might possess severely handicapping malocclusion, evidenced by interference with the ability to chew and talk, and yet not receive a score of 42 on the Salzmann index.[40]

In *Jacobus v. Department of PATH*, the Supreme Court of Vermont held that the failure of Department of Assistance, Transition and Health Access (PATH) to provide individualized review to two Medicaid-enrolled children requesting interceptive orthodontia violated the Medicaid Act.[41] The Court found that PATH regulations allowed two avenues for obtaining orthodontia; the first required demonstration that the child had one major or two minor malocclusions, as defined by PATH's diagnostic criteria, while the second avenue provided Medicaid coverage of orthodontic services if "otherwise necessary under EPSDT."[42] Despite the existence of the second avenue, PATH did not conduct an individualized review of the children's conditions to see if treatment was "otherwise necessary" and denied orthodontic services based on the fact that the children did not satisfy the first avenue.[43]

The Court also determined that PATH violated the comparability provision of the Medicaid Act in its establishment of different standards for children needing interceptive orthodontic services and those requiring comprehensive orthodontia.[44] Instead of satisfying the first prong by showing that she had one major or two minor malocclusions, a Medicaid-enrolled

---

[35] *Id.*

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] *Id.*

[40] *Id.*

[41] *See* Jacobus v. Department of PATH, 857 A.2d 785 (Vt. 2004).

[42] *See id.* at 788.

[43] *Id.*

[44] *See id.* at 790.

child could meet the second prong requirements by demonstrating that orthodontia was "otherwise necessary under EPSDT." The Court found that to be deemed "medically necessary" by the Secretary of Human Services, the child had to possess ". . . serious handicapping malocclusions, those malocclusions that carry with them real functional deficit."[45] Therefore, while a child needing comprehensive orthodontia could conceivably satisfy either test, one requiring interceptive orthodontia, to prevent a developing malocclusion, could only satisfy the first because the child had not yet developed a "real functional deficit." The different standards, the Court found, resulted in discrimination based upon diagnosis or condition and violated the comparability provisions of the Medicaid Act and regulations requiring that "medical assistance made available to any individual . . . shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual."[46]

Like the courts in *Chappell* and *Jacobus*, the Connecticut Superior Court held that the state could not deny orthodontia coverage to children who failed to meet the predetermined threshold requirements of scoring a minimum of 24 points on the Salzmann index, or otherwise demonstrate some severe deviation or severe mental, emotional or behavioral problems resulting from orthodontic issues.[47] In *Semerzakis v. Wilson-Coker*, the Court found that EPSDT provisions in the Medicaid Act mandating the coverage of "such other necessary health care . . . to correct or ameliorate defects whether or not such services are covered under the State plan" signified that the State had to actually determine whether orthodontic services were "necessary."[48] Furthermore, the Court determined that the decision by the Commissioner of the Department of Social Services to deny orthodontic services to the plaintiff imposed an additional criterion of "irreversibility" not required in Connecticut's state plan or the Medicaid Act.[49]

As Medicaid beneficiaries in several states were able to successfully challenge the denial of orthodontia coverage through the courts, children seeking coverage in California's Medi-Cal program were able to bring forth similar policy change through legal settlements. There, Medicaid beneficiaries sued the Department of Health Services to obtain coverage of medically necessary orthodontic services through the Children's Health and Disability Prevention Program,

---

[45] *Id.*

[46] *Id.* (citing 42 U.S.C. §§ 1396a(a)(17), 1396a(a)(10)B)(i); 42 C.F.R. §§ 440.240(b) and 440.230(c)).

[47] *See* Semerzakis v. Wilson-Coker, No. CV030520876S, 2003 Conn. Super. LEXIS 3478 (Conn. Super. Ct. December 24, 2003).

[48] *See id.* at *8.

[49] *See id.* at *9.

California's version of EPSDT.[50] The parties in *Brown v. Kizer* settled the case, agreeing that the Department would provide orthodontic services to the plaintiff children and would adopt regulations mandating "medically necessary orthodontic services for the treatment of handicapping malocclusion for individuals under 21 years of age . . . ."[51] As a result of the settlement, the Manual of Criteria for Medi-Cal Authorization was amended to mandate the use of the HLD index as a preliminary tool to determine the degree of handicapping malocclusion and establish the medical necessity of orthodontia for handicapping malocclusion.[52] Children seeking orthodontia would be required to obtain a minimum score of 26 points on the HLD index or otherwise demonstrate one of three conditions.[53] Following *Brown v. Kizer*, Medicaid beneficiaries brought another lawsuit, *Duran v. Belshe*, which ended in a settlement agreement stipulating that the Department would promulgate emergency regulations that allowed the use of an expanded HLD Index.[54] Finally, a third lawsuit, *Smith v. Belshe*, led to the addition of an EPSDT exception as part of the process for providing Medicaid authorization for orthodontia.[55] As a result of these three lawsuits, a child who did not score 26 or above on the HLD index and did not meet one of the five automatic qualifying conditions could still obtain orthodontia under the EPSDT exception if medical necessity was documented by the child's dental provider.[56]

---

[50] *See* Brown v. Kizer, Complaint for Injunctive and Declaratory Relief and Damages and Petition for Writ of Mandate, No. 641954-3 (Sup. Ct. Cal. August 16, 1988).

[51] *See* Brown v. Kizer, Settlement Agreement, No. 641954-3 (Sup. Ct. Cal. Dec. 23, 1989).

[52] *See id.* at Exhibit A.

[53] *Id.* Conditions automatically considered to be handicapping malocclusions without further measuring and scoring on the HLD index included 1) cleft palate deformities, 2) deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate, and 3) crossbite of individual anterior teeth that is destroying soft tissue. Current guidelines require a score of 26 on the HLD index or any of five automatically qualifying conditions, including the three listed above, overjet greater than 9 mm with incompetent lips, or reverse overject greater than 3.5 mm with reported masticatory and speech difficulties or severe traumatic deviations. *See* California Medi-Cal Dental Program, DENTI-CAL PROVIDER MANUAL 4-45 - 4-48 (March 2004).

[54] *See* Children's Advocacy Institute, THE CHILDREN'S REGULATORY LAW REPORTER, Vol. 1, No. 2 (1998)(discussing Duran v. Belshe, No. 674204 (Sup.Ct. Cal. 1994) (*available at* http://www.caichildlaw.org/Reg_Law_Rep_Vol_1_No_2/Reg_Law_Rep_Vol_1_No_2.htm#ch).

[55] *See* Smith v. Belshe, No. CV-S-93-1782 LKK PAN (E.D. Cal. 1994).

[56] *See* California Medi-Cal Dental Program, DENTI-CAL PROVIDER MANUAL 4-46, 4-47 (March 2004).

Advocacy Tips

The first step advocates must take in assisting a client who seeks orthodontic services through Medicaid is to determine exactly what criteria your state considers in authorizing treatment. This includes understanding the authorization process and the index or standards which the state utilizes. Advocates should obtain from dental providers documentation indicating that orthodontia is medically necessary; a letter or affidavit from the treating orthodontist should include EPSDT terminology such as "maintain dental health," "relieve pain and infection," and "correct or ameliorate the defect." It is also important that the documents not simply describe the child's conditions, but explain what the treatment will accomplish. If your client has already sought and been denied orthodontic services, you can challenge the decision through a fair hearing, offering new or different evidence of medical necessity from orthodontists, dentists, physicians as well as family members. If she is denied services at the administrative hearing, you should consider another appeal to challenge the authorization process as well as the denial itself.

Advocates working in states that utilize an index such as HLD or Salzmann, must understand how the index was used in the state's determination. Was the index part of the utilization control process to verify medical necessity? Or did its application simply serve to narrow the definition of medical necessity and deny your client and other Medicaid beneficiaries orthontia? As the Court in *Brooks v. Smith* noted, utilization control processes cannot be undertaken to deny treatment authorized by federal Medicaid law. One way to make that determination is to evaluate if the process involved an individualized assessment or merely required the satisfaction of one or more bright line rules, such as receiving a qualifying score on an occlusal index. If it was the latter, you may be able to challenge the procedures based upon *Chappell v. Bradley*. Citing CMS' *Guide to Children's Dental Care in Medicaid*, you can argue that screening tools are only one component of the medically necessity determination and that your client should be afforded individualized consultations with dental and orthodontic providers. Even if an individualized assessment is a part of the authorization process, you should examine whether different criteria or criteria that is more stringent than a qualifying score on an index are required in such an assessment. If that is the case, you may be able to challenge the criteria as a violation of the comparability provisions of the Medicaid Act. Whether your state allows an explicit EPSDT exception to authorize orthodontia or not, you should argue that the state must ultimately evaluate your client's need based upon EPSDT definitions of medical necessity: "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."[57]

---

[57] *See* 42 U.S.C. § 1396d(r); *see also* H.R. Report, No. 101-249 (1989) (explaining that "[w]hile States may use prior authorization and other utilization controls to ensure that treatment services are medically necessary, these controls must be consistent with the preventive thrust of the EPSDT benefit").

In challenging state policies on orthodontia, advocates should remember that in the Medicaid Act and regulations, there is no mention of "handicapping malocclusion," "severe malocclusion" or "most handicapping malocclusion," which states often use to describe conditions that warrant orthodontic services. While the State Medicaid Manual refers to handicapping malocclusion, it provides no definition of the term. Furthermore, it is not clear that the HLD and Salzmann index capture every case of handicapping malocclusion. Rather, the literature indicates that the indices merely quantify some types of deviation, but not others. That states using the same index score conditions differently and authorize orthodontia based upon different scores demonstrates that the indices do not measure medical necessity. Moreover, the fact that orthodontia would be deemed medically necessary for a child in one state, but not medically necessary for the same child, if she lived in another state, leads to the conclusion that the indices are simply arbitrary cut-offs for denying orthodontic services. For that reason, advocates should urge their states to move beyond state-specific authorization processes, which include the use of occlusal indices, and instead rely solely on federal EPSDT law.[58] They should seek for their clients Medicaid coverage of orthodontic services to treat "handicapping or *other* malocclusions" as is medically necessary.[59]

Resources for Advocates

- National Health Law Program
- www.healthlaw.org 22233

- Centers for Medicare and Medicaid Services
  www.cms.hhs.gov

- National Association of Orthodontists
  www.braces.org

[58] *See* S.D. v. Hood, 391 F.3d. 581, 592 (5d. Cir. 2004)(stating "the plain words of the statute and the legislative history make evident that Congress intended that the health care, services, treatment and other measures that must be provided under the EPSDT program be determined by reference to federal law, not state preferences").

[59] *See* CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 8, at 12.