Iowa Department of Human Services

Addendum to Dental Provider Agreement for Orthodontia

I. I, the undersigned, hereby agree to provide orthodontia treatment for Iowa Medicaid recipients in exchange for Medicaid reimbursement.

II. I understand that the following are conditions of Medicaid reimbursement:

A. Prior authorization for Orthodontia treatment must be approved by the Iowa Medicaid Enterprise (IME) before the Orthodontia treatment begins. All Orthodontia treatment plans submitted in accordance with this agreement will be reviewed within 30 days.

B. The recipient must be eligible for Medicaid benefits on the date treatment is to begin. Upon approval and receipt of a properly completed claim form for a recipient meeting the requirements, the entire amount, up to the current fee schedule amount, will be reimbursed to the provider, whether or not the recipient becomes ineligible for Medicaid after Orthodontia treatment is started.

C. This agreement must be signed by the dental provider.

D. Only recipients age 20 and under on the date treatment is to begin are eligible for prepayment of Orthodontia treatment.

III. To receive Medicaid reimbursement, I agree:

A. To sign this Orthodontia Agreement and submit it to the IME. The Orthodontia Agreement will be part of the provider enrollment agreement. One agreement will cover the treatment of all recipients.

B. To submit a completed prior authorization and appropriate documentation to the IME in accordance with the current Prior Authorization requirements. All documentation material will be returned immediately following the review of the case. If the recipient is eligible on the date these services are rendered, reimbursement will be made for the Orthodontia exam and documentation, even in the event the prior authorization request is denied.

C. Upon receipt of approved prior authorization, to discuss with the recipient the method used by Medicaid to pay for these services.

D. To submit all claims for payment in compliance with the rules and regulations in effect at the time of submission.

E. To accept Medicaid payment as payment in full.

F. To continue treatment to conclusion without additional charge to the recipient, even if the recipient becomes ineligible for Medicaid.

G. To notify the IME immediately if the recipient or the provider terminates treatment or transfers.

H. The IME in coordination with the Dental Consultant will determine the amount of money to be refunded by the provider if treatment terminates or the recipient transfers to another provider before the entire course of treatment is completed. This amount will be based on the number of months needed to complete the remaining portion of the course of treatment. The IME will notify the provider of the amount to be refunded. The provider must return this amount to the IME. Assuming normal progress of the course of treatment for those cases terminated prior to 30 months from the initial application of appliances, the following formula will be applied to determine the amount to be refunded.

Month during which service terminates	Percentage Remitted
1	73% of total allowance
2	70.89% of total allowance
3	68.78% of total allowance
4	66.67% of total allowance
5	64.56% of total allowance
6	62.45% of total allowance
7	60.34% of total allowance
8	58.23% of total allowance
9	56.12% of total allowance
10	54.01% of total allowance
11	51.90% of total allowance
12	49.79% of total allowance
13	47.68% of total allowance
14	45.57% of total allowance
15	43.46% of total allowance
16	41.35% of total allowance
17	39.24% of total allowance
18	37.13% of total allowance
19	35.02% of total allowance
20	32.91% of total allowance
21	30.80% of total allowance
22	28.69% of total allowance
23	26.58% of total allowance
24	24.47% of total allowance
25	22.36% of total allowance
26	20.25% of total allowance
27	18.14% of total allowance
28	16.03% of total allowance
29	13.92% of total allowance
30	11.81% of total allowance

IV. Orthodontia Certification

I have read this Addendum to the Dental Provider Agreement for Orthodontia and accept its provisions.

_____ _____

Signature of Orthodontia Provider Date

_____ _____

Street Address City, State, Zip

_____

Provider Number/National Provider Identifier