

Orthodontic Information

MEDICAID AUTHORIZATIONS – ORTHO
PO Box 45535
Olympia, WA 98504-5535

All blank fields below must be completed; please see example form on page 4.

Provider name	Patient's name: Last	First	MI	Sex																
Billing provider number	Performing provider number																			
Client ID	Client birth date	Client age: years/months																		
PART I. Orthodontic treatment requested (check box below) and diagnostic information																				
<input type="checkbox"/> Case study only <input type="checkbox"/> Fixed appliance therapy <input type="checkbox"/> Limited transitional treatment <input type="checkbox"/> Interceptive treatment <input type="checkbox"/> Comprehensive full treatment <input type="checkbox"/> Transfer case (if check, indicate months required to complete treatment)																				
Tentative treatment plan:																				
Functional concerns:																				
Will the client require orthognathic surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
Has the client seen a general dentist in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
Stage of dentition: <input type="checkbox"/> Primary <input type="checkbox"/> Adolescent <input type="checkbox"/> Mixed/Transitional Anterior teeth:			Brief initial opinions																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Overjet</td> <td style="width: 25%;"></td> <td style="width: 10%;">mm</td> <td style="width: 5%;"></td> </tr> <tr> <td>Overbite</td> <td></td> <td>mm</td> <td></td> </tr> <tr> <td>Openbite</td> <td></td> <td>mm</td> <td></td> </tr> <tr> <td>Midline</td> <td></td> <td>mm</td> <td></td> </tr> </table>			Overjet		mm		Overbite		mm		Openbite		mm		Midline		mm		Client's chief complaint	
Overjet		mm																		
Overbite		mm																		
Openbite		mm																		
Midline		mm																		
<u>Crossbite:</u> Indicate teeth involved _____			Habits																	
Posterior teeth: <u>Angle Classification:</u> Skeletal classification: (check one) <input type="checkbox"/> Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III Dental classification: (check one) Right <input type="checkbox"/> Class I <input type="checkbox"/> E to E <input type="checkbox"/> Class II <input type="checkbox"/> Class III Left <input type="checkbox"/> Class I <input type="checkbox"/> E to E <input type="checkbox"/> Class II <input type="checkbox"/> Class III <u>Crossbite:</u> Indicate teeth involved _____			Musculature: tone and function																	
Anterior Crowding (Approximate) Spacing			Symmetry of arches																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">MAX</td> <td style="width: 10%;"></td> <td style="width: 10%;">mm</td> </tr> <tr> <td>MAND</td> <td></td> <td>mm</td> </tr> </table>			MAX		mm	MAND		mm	Temporomandibular dysfunction											
MAX		mm																		
MAND		mm																		
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;">MAX</td> <td style="width: 10%;"></td> <td style="width: 10%;">mm</td> </tr> <tr> <td>MAND</td> <td></td> <td>mm</td> </tr> </table>			MAX		mm	MAND		mm												
MAX		mm																		
MAND		mm																		

Missing teeth (list)			Oral hygiene: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Ectopic eruption (Numbers of teeth excluding third molar(s):	Yes <input type="checkbox"/>	Tooth/location	Restoration or caries problems		
Missing (indicate teeth):	<input type="checkbox"/>				
Impacted (indicate teeth):	<input type="checkbox"/>				
Ankylosed (indicate teeth):	<input type="checkbox"/>				
Supernumerary (indicate location):	<input type="checkbox"/>				
Other medical or dental problems:					
PART II. Overbite, crossbite or overjet information. See instructions for further information.					
Place an "x" for each condition that applies					
1. Client has a deep impinging overbite when lower incisors are destroying the soft tissue of the palate. Photographic evidence that confirms deep impinging overbites when the lower incisors are destroying the soft tissue of the palate must be submitted.					<input type="checkbox"/>
2. Client has a crossbite of individual anterior teeth when destruction of the soft tissue is present. Recession of labial gingival tissue due to crossbite must be more than 1mm and the recession must not be due to the lower crowding but directly related to the anterior crossbite.					<input type="checkbox"/>
3. Client has an overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory and speech difficulties. If this is applicable, provide a color photo using either a probe or ruler to demonstrate the condition.					<input type="checkbox"/>
4. Client has a negative overjet relative to a skeletal Class III. A recent cephalometric radiographic image must be submitted to confirm this condition.					<input type="checkbox"/>
PART III. Handicapping Labiolingual Deviation Index (HLD). See instructions regarding scoring.					
1. Overjet in mm.					
2. Overbite in mm.					
3. Mandibular protrusion.					X 5 =
4. Openbite in mm.					X 4 =
If both anterior crowding and ectopic eruptions are present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.					
5. Ectopic eruption: Count each tooth, excluding third molars					X 3 =
6. Anterior crowding: Anterior arch length insufficiency must exceed 3.5mm; score one point for maxilla and one point for mandible; 2 points maximum for anterior crowding. The maximum number of points for this item is therefore 10 points (5 upper and 5 lower).					X 5 =
7. Posterior unilateral crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of 4 on the scoresheet. If both left and right posterior crossbite are present, score 4 for each side.					
PROVIDER'S ESTIMATED TOTAL HLD SCORE (REQUIRED)					
PLEASE NOTE: The HLD scoring is a guideline for your use and reference, and rescoring may be completed by our consultants. You will still be required to send all required information referred to in Billing Instruction and WAC. The department will make the final decision regarding medical necessity and scoring. This information may not be used to predetermine coverage in order to charge the client.					
Examination completed by: Print name					Date
I certify that I am the performing provider and that the medical necessity information is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in those sections may subject me to civil or criminal liability.					
PERFORMING PROVIDER SIGNATURE			Print name (INCLUDE CREDENTIALS)		Date

Part II Overbite, crossbite or overjet information instructions

1. **Deep impinging overbite:** Indicate an "X" on the scoresheet when lower incisors are destroying the soft tissue of the palate. Only the maxillary central incisors can be utilized for the measurement of overbite. Tissue contact without visible destruction will not be considered as impingement.
2. **Crossbite of individual anterior teeth:** Indicate an "X" on the scoresheet when destruction of soft tissue is present. Recession of labial gingival tissue due to crossbite must be more than 1mm and the recession must not be due to the lower crowding but directly related to the anterior crossbite.
3. **Overjet greater than 9mm:** Indicate an "X" on the scoresheet if the overjet is greater than 9mm with incompetent lips or the reverse overjet (mandibular protrusion) is greater than 3.5mm with reported masticatory and speech difficulties. If the reverse overjet is not greater than 3.5mm, score under Part III, #1.
4. **Negative overjet:** Indicate an "X" on the scoresheet if there is an absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters and the measurement is made at the central incisors. In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated. A recent cephalometric film must be submitted to confirm this condition.

Part III Handicapping labiolingual index scoring instructions for severe malocclusion

The intent of the HLD Index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose "malocclusion." All measurements are made with a disposable ruler scaled in millimeters or a periodontal probe scaled in millimeters. Absence of any conditions must be recorded by entering "O" (refer to scoresheet).

The following information should help clarify the categories on the HLD Index:

1. **Overjet in millimeters:** This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper central incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the scoresheet.
2. **Overbite in millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the scoresheet. The measurement is taken at the central incisors.
3. **Mandibular protrusion in millimeters:** Score exactly as measured from the labial of the lower incisor to the labial of the upper central incisor. The measurement in millimeters is entered on the scoresheet and multiplied by five (5). Confirm the mandibular protrusion with a cephalometric x-ray or a perio probe.
4. **Openbite in millimeters:** The absence of vertical overlap of the upper central incisors relative to the incisal edges of the lower incisors when the posterior teeth are in contact. The distance is measured (or when a significant overjet is present estimated) in millimeters from the incisors of the upper centrals to the incisors of the lower anteriors with the posterior teeth in maximum contact. This measurement is entered on the scoresheet and multiplied by four (4).
5. **Ectopic eruption:** Count each tooth, excluding third molars. Enter the number of teeth on the scoresheet and multiply by three (3). If condition #5, anterior crowding, is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. **Do not score both conditions.**
The customary and accepted conditions of dental ectopia include ectopic eruption such as that when a portion of the distal root of the primary second molar is resorbed during the eruption of the first molar. These include transposed teeth. Also included are teeth in the maxillary sinus, in the ascending ramus of the mandible and other such situations, when teeth develop in other locations, rather than in the dental arches. These are classic textbook examples of ectopic eruption and development of teeth. In all other situations, teeth deemed to be ectopic must be more than 50 percent blocked out and clearly out of the dental arch. Regarding mutually blocked out teeth, only one will be counted.
6. **Anterior crowding:** Arch length insufficiency must exceed 3.5mm in the anterior segment. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter 5 points each for maxillary and mandibular anterior crowding. If condition #4, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. **Do not score both conditions.**
7. **Posterior unilateral crossbite:** This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of 4 on the scoresheet.

Additional requirements

- All information pertaining to medical necessity must come from the client's prescribing orthodontist. Information obtained from the client or someone on behalf of the client (e.g., family) will not be accepted.
- Measurement, counting, recording, or consideration for treatment is performed only on teeth that have erupted and can be seen on the diagnostic study models. All measurements are made or judged on the basis equal to, or greater than the minimum requirement.
- Only permanent natural teeth will be considered for full orthodontic treatment of severe malocclusions.
- Use either of the upper central incisors when measuring overjet, overbite (including reverse overbite), mandibular protrusion, and openbite. The upper lateral incisors or upper canines may not be used for these measurements.
- A single impacted tooth alone is not considered a severe handicapping malocclusion.

EXAMPLE:

Washington State Health Care Authority
Orthodontic Information
 MEDICAID AUTHORIZATIONS - ORTHO
 PO Box 45535
 Olympia, WA 98504-5535

All blank fields below must be completed; please see example form on page 4.

Provider name Dr. Orthodontist	Patient's name: Last Doe	First John	MI	Sex M
Billing provider number 1234567890	Performing provider number 9876543210			
Client ID 123456789WA	Client birth date 1/1/2000	Client age: years/months 17years/4mo		

PART I. Orthodontic treatment requested (Check box below and diagnostic information)

Case study only
 Fixed appliance therapy
 Limited transitional treatment
 Interceptive treatment
 Comprehensive full treatment
 Transfer case (if check, indicate months required to complete treatment)

Tentative treatment plan:
Comprehensive orthodontic treatment (includes final records and retention)

Functional concerns:
N/A

Will the client require orthognathic surgery? Yes No

Has the client seen a general dentist in the last 12 months? Yes No

Stage of dentition: <input type="checkbox"/> Primary <input checked="" type="checkbox"/> Adolescent <input type="checkbox"/> Mixed/Transitional	Brief initial opinions
Anterior teeth: Overjet: 2 mm Overbite: N/A mm Openbite: 1 mm Midline: 1 mm	Client's chief complaint N/A Habits N/A
Crossbite: Indicate teeth involved N/A	Musculature: tone and function N/A Symmetry of arches Poor
Posterior teeth: Ankle Classification: Skeletal classification: (check one) <input checked="" type="checkbox"/> Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III Dental classification: (check one) Right <input checked="" type="checkbox"/> Class I <input type="checkbox"/> E to E <input type="checkbox"/> Class II <input type="checkbox"/> Class III Left <input checked="" type="checkbox"/> Class I <input type="checkbox"/> E to E <input type="checkbox"/> Class II <input type="checkbox"/> Class III Crossbite: Indicate teeth involved N/A	Temporomandibular dysfunction N/A

Anterior Crowding (Approximate)	Spacing
MAX 4 mm MAND 4 mm	MAX N/A mm MAND N/A mm

HCA 13-866 (5/17)

Missing teeth (list)	Yes	Tooth/location	Oral hygiene: <input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Ectopic eruption (Numbers of teeth excluding third molar(s)):	<input type="checkbox"/>	N/A	Restoration or caries problems TMJ symptoms include clicking/popping left side
Missing (indicate teeth):	<input type="checkbox"/>	N/A	
Impacted (indicate teeth):	<input type="checkbox"/>	N/A	
Ankylosed (indicate teeth):	<input type="checkbox"/>	N/A	
Supernumerary (indicate location):	<input type="checkbox"/>	N/A	
N/A medical or dental problems:			

PART II. Overbite, crossbite or overjet information. See instructions for further information.

Place an "x" for each condition that applies

1. Client has a deep impinging overbite when lower incisors are destroying the soft tissue of the palate.	<input type="checkbox"/>
2. Client has a crossbite of individual anterior teeth when destruction of the soft tissue is present. Recession of labial gingival tissue due to crossbite must be more than 1mm and the recession must not be due to the lower crowding but directly related to the anterior crossbite.	<input type="checkbox"/>
3. Client has an overjet greater than 9mm with incompetent lips or reverse overjet greater than 3.5mm with reported masticatory and speech difficulties. If this is applicable provide a color photo using either a probe or ruler to demonstrate the 9mm or greater overjet.	<input type="checkbox"/>
4. Client has a negative overjet relative to a skeletal Class III. A recent cephalometric radiographic image must be submitted to confirm this condition.	<input type="checkbox"/>

PART III. Handicapping Labiolingual Deviation Index (HLD). See instructions regarding scoring.

1. Overjet in mm.	2
2. Overbite in mm.	0
3. Mandibular protrusion.	0
4. Openbite in mm.	4

If both anterior crowding and ectopic eruptions are present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.

5. Ectopic eruption: Count each tooth, excluding third molars	0
6. Anterior crowding: Anterior arch length insufficiency must exceed 3.5mm; score one point for maxilla and one point for mandible; 2 points maximum for anterior crowding. The maximum number of points for this item is therefore 10 points (5 upper and 5 lower).	10
7. Posterior unilateral crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of 4 on the scoresheet. If both left and right posterior crossbite are present, score 4 for each side.	0

PROVIDER'S ESTIMATED TOTAL HLD SCORE (REQUIRED)

16

PLEASE NOTE: The HLD scoring is a guideline for your use and reference, and scoring may be completed by our consultants. You will still be required to send all required information referred to in Billing Instruction and WAC. The department will make the final decision regarding medical necessity and scoring. This information may not be used to predetermine coverage in order to charge the client.

Examination completed by: Doctor Orthodontist DDS, MS	Date: 5/1/17
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I certify that I am the performing provider and that the medical necessity information is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in those sections may subject me to civil or criminal liability.

PERFORMING PROVIDER SIGNATURE: _____	Print name (INCLUDE CREDENTIALS) Doctor Orthodontist DDS, MS	Date 5/1/17
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HCA 13-866 (12/16)