Ohio Clinical Orthodontic Services

Plan	Anthem
Exhibit	AN-UM01-INS-I-D800-Orthodontic Services
Criteria	Orthodontic Services
Prior Authorization	Yes

A. D8080, D8670, D8680 Orthodontic Treatment

Description

Orthodontics and dentofacial orthopedics are the dental specialty that includes diagnosis, prevention, interception, and correction of a non-functional and often handicapping malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures. The purpose of an orthodontic procedure is to reposition teeth in a dental arch and influence skeletal and muscular changes in the oral and maxillofacial complex. This restores health, occlusion, esthetics, or any combination to an acceptable treatment result.

Policy/Criteria

1. **It is the policy of Liberty Dental Plan that comprehensive orthodontic treatment of the adolescent dentition is <u>medically necessary</u> when one or more of the following conditions are met:**
    a. When overjet is greater than 9.0 mm.
    b. When reverse overjet is greater than 3.5 mm.
    c. When there is anterior crossbite of two (2) teeth with evidence of gingival recession.
    d. When there is an impinging overbite with tissue laceration and/or clinical attachment loss.
    e. When there are anterior impactions where eruption is impeded but extraction is not indicated (excluding third molars).
    f. When jaws and/or dentition are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma, or pathology.
    g. When there is crowding greater than 8.0 mm in the maxillary arch only.
    h. When none of the previous conditions apply but the member's condition results in a verified score of 22 points or greater on ODM Form 03630 (see Attachment A at the end of this policy document).

i. When the patient experiences clinically significant distress or impaired psychosocial functioning substantially contributed to by the patient's malocclusion. This is supported by a diagnosis verified with documentation from a psychologist or psychiatrist following a screening examination or interview. Score as 10 points, then add points from Conditions 8, 10. 11, 12, 14, and 16 for total score.

j. When the patient experiences significant speech impairment which is diagnosed as a speech or language pathology caused by the patient's malocclusion. This is verified with documentation from a speech therapist following a screening evaluation or interview. Score as 10 points, then add points from Conditions 8, 10. 11, 16, and 17 for total score.

k. When none of the following contraindications apply:

   i. When there is a crowded dentition (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions, and/or cosmetic purposes.

   ii. When a limited orthodontic phase of treatment corrects the qualifying conditions for medical necessity.

   iii. When the member has unmet preventive care needs or is not current on restorative treatment needs.

l. Required documentation to support medical necessity include the following:

   i. A current (within six months) diagnostic quality cephalometric image with a calibration gauge on the image.

   ii. A current (within six months) diagnostic quality panoramic image.

   iii. Current diagnostic-quality eight-view full color composite photographic images including diagnostic maxillary and mandibular occlusal views. Claims of overjet, overbite, open bite, and crowding should be verified with a measurement, or photographic image with a measurement. For the extraoral images, the teeth should be in centric occlusion with the lips relaxed when not smiling.

   iv. A definitive diagnosis and comprehensive treatment plan with treatment timeline.

   v. Clinical chart/treatment notes documenting conditions supporting the diagnosis and treatment plan.

   vi. A completed ODM Form 03630.

   vii. A letter of definitive psychosocial injury diagnosis and treatment notes from the member's psychiatrist, psychologist, or speech pathologist, whichever is applicable.

2. Categories of Orthodontic Treatment

a. Comprehensive orthodontic treatment of adolescent dentition (D8080) is indicated when:

   i. There is a need to correct medically necessary dentofacial issues including any skeletal, muscular, and/or dental disharmony issues in an adolescent dentition (D8080).

   ii. All permanent teeth except third molars are present or soon to erupt unless permanent teeth are missing or impacted. This generally begins at age 10 years for females and 12 years for males.

   iii. Treatment may involve dental and medical specialists including general and pediatric dentists, periodontists, oral surgeons, ENT physicians, psychiatrists, psychologists, and speech pathologists/therapists.

   iv. Treatment may require the use of the following:

      1. Rapid palatal expander (RPE)
      2. Appliances to gain or maintain space
      3. Appliances designed to moderate or guide skeletal growth
      4. Headgear

5. Herbst appliance
6. Other growth modifiers

3. Coverage Limitations/Exclusions

a. Limited to members under the age of 21 and the following codes:

CDT® Codes	Description
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8670	Periodic orthodontic treatment visit
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))

b. The above-listed codes require prior authorization approval.

c. An approved Medicaid orthodontic case is honored to completion of the case regardless of the member's age.

d. Fees for orthodontic appliances, including but not limited to, headgear, rapid palatal expanders, Herbst appliances, and other growth modifiers are included in the case fee for the approved comprehensive orthodontic treatment of the adolescent dentition:

1. Payments for approved prior authorizations for D8080 and D8670 are to be made as follows:

i. Upon receipt of a claim for D8080, a payment for the lesser of the provider's actual charge, the plan's contracted fee, or the amount listed in the most current version of OAC 5160.1.60 – Appendix DD, subject to any state-mandated adjustments for rural providers, shall be made. This payment includes the banding/bracketing services and the first of eight quarterly payments.

ii. Upon receipt of a claim for D8670 in each subsequent quarter totaling seven (7) quarters, a payment for the lesser of the provider's actual charge, the plan's contracted fee, or the amount listed in the most current version of OAC 5160.1.60 – Appendix DD, subject to any state-mandated adjustments for rural providers, shall be made.

iii. These eight payments are for treatment of the entire D8080 case regardless of the length of time required to complete the case. Appliances, headgear, etc. are included in the total payment amount for the lesser of the provider's actual charges, the plan's contracted fees, or the combined amounts for D8080 and the remaining seven (7) quarterly payments for D8670 listed in the most current version of OAC 5160.1.60 – Appendix DD, subject to any state-mandated adjustments for rural providers.

2. Payment for D8670 requires a previously approved D8080 on record for the member.

3. Payment for D8680 requires a previously approved D8080 on record for the member and photographic evidence of satisfactory case completion.

4. Coding Implications

This clinical policy references Current Dental Terminology (CDT®). CDT® is a registered trademark of the American Dental Association. All CDT codes and descriptions are copyrighted 2025, American Dental Association. All rights reserved. CDT codes and CDT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Retrospective review/analysis or fraud, waste and abuse initiatives that identify mis-coding (upcoding) resulting in higher reimbursement than allowed for the correctly coded service, or does not provide documentation supporting performing and/or completing claimed services may result in the recoupment of the identified monetary variance by any of the following means: a) from the payment for other claimed services; or b) directly from the provider.

CDT® Codes	Description
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8670	Periodic orthodontic treatment visit
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))

Partial List of ICD-10-CM Diagnosis Codes that Support Coverage Criteria, Others May Apply

ICD-10-CM Code	Description
K00.0	Anodontia
K00.1	Supernumerary teeth
K00.2	Abnormalities of size and form of teeth
K00.3	Mottled teeth
K00.4	Disturbances in tooth formation
K00.5	Hereditary disturbances in tooth structure, not elsewhere classified
K00.6	Disturbances in tooth eruption
K00.7	Teething syndrome
K00.8	Other disorders of tooth development
K00.9	Disorder of tooth development, unspecified
K01.0	Embedded teeth
K01.1	Impacted teeth
K08.401	Partial loss of teeth, unspecified cause, class I
K08.402	Partial loss of teeth, unspecified cause, class II
K08.403	Partial loss of teeth, unspecified cause, class III
K08.404	Partial loss of teeth, unspecified cause, class IV
K08.409	Partial loss of teeth, unspecified cause, unspecified class
K08.411	Partial loss of teeth due to trauma, class I
K08.412	Partial loss of teeth due to trauma, class II
K08.413	Partial loss of teeth due to trauma, class III
K08.414	Partial loss of teeth due to trauma, class IV
K08.419	Partial loss of teeth due to trauma, unspecified class
K08.421	Partial loss of teeth due to periodontal diseases, class I
K08.422	Partial loss of teeth due to periodontal diseases, class II
K08.423	Partial loss of teeth due to periodontal diseases, class III
K08.424	Partial loss of teeth due to periodontal diseases, class IV
K08.429	Partial loss of teeth due to periodontal diseases, unspecified class
K08.431	Partial loss of teeth due to caries, class I
K08.432	Partial loss of teeth due to caries, class II
K08.433	Partial loss of teeth due to caries, class III
K08.434	Partial loss of teeth due to caries, class IV
K08.439	Partial loss of teeth due to caries, unspecified class
K08.491	Partial loss of teeth due to other specified cause, class I
K08.492	Partial loss of teeth due to other specified cause, class II
K08.493	Partial loss of teeth due to other specified cause, class III

ICD-10-CM Code	Description
K08.494	Partial loss of teeth due to other specified cause, class IV
K084.99	Partial loss of teeth due to other specified cause, unspecified class
K08.50	Unsatisfactory restoration of tooth, unspecified
K08.51	Open restoration margins of tooth
K08.52	Unrepairable overhanging of dental restorative materials
K08.530	Fractured dental restorative material without loss of material
K08.531	Fractured dental restorative material with loss of material
K08.539	Fractured dental restorative material, unspecified
K08.54	Contour of existing restoration of tooth biologically incompatible with oral health
K08.55	Allergy to existing dental restorative material
K08.56	Poor aesthetic of existing restoration of tooth
K08.59	Other unsatisfactory restoration of tooth
K08.81	Primary occlusal trauma
K08.82	Secondary occlusal trauma
K08.89	Other specified disorders of teeth and supporting structures
K08.9	Disorder of teeth and supporting structures, unspecified
M26.01	Maxillary hyperplasia
M26.02	Maxillary hypoplasia
M26.03	Mandibular hyperplasia
M26.04	Mandibular hypoplasia
M26.05	Macrogenia
M26.06	Microgenia
M26.07	Excessive tuberosity of jaw
M26.10	Unspecified anomaly of jaw-cranial base relationship
M26.11	Maxillary asymmetry
M26.12	Other jaw asymmetry
M26.19	Other specified anomalies of jaw-cranial base relationship
M26.20	Unspecified anomaly of dental arch relationship
M26.211	Malocclusion, Angle’s class I
M26.212	Malocclusion, Angle’s class II
M26.213	Malocclusion, Angle’s class III
M26.220	Open anterior occlusal relationship
M26.221	Open posterior occlusal relationship
M26.23	Excessive horizontal overlap
M26.24	Reverse articulation
M26.25	Anomalies of interarch relationship
M26.29	Other anomalies of dental arch relationship
M26.30	Unspecified anomaly of tooth position of fully erupted tooth or teeth
M26.31	Crowding of fully erupted teeth
M26.32	Excessive spacing of fully erupted teeth
M26.33	Horizontal displacement of fully erupted tooth or teeth
M26.34	Vertical displacement of fully erupted tooth or teeth
M26.35	Rotation of fully erupted tooth or teeth
M26.36	Insufficient interocclusal distance of fully erupted teeth (ridge)
M26.37	Excessive interocclusal distance of fully erupted teeth
M26.39	Other anomalies of tooth position of fully erupted tooth or teeth
M26.4	Malocclusion, unspecified
M26.50	Dentofacial functional abnormalities, unspecified

ICD-10-CM Code	Description
M26.51	Abnormal jaw closure
M26.52	Limited mandibular range of motion
M26.53	Deviation in opening and closing of the mandible
M26.54	Insufficient anterior guidance
M26.55	Centric occlusion maximum intercuspation discrepancy
M26.56	Non-working side interference
M26.57	Lack of posterior occlusal support
M26.59	Other dentofacial functional abnormalities
M26.70	Unspecified alveolar anomaly
M26.71	Alveolar maxillary hyperplasia
M26.72	Alveolar mandibular hyperplasia
M26.73	Alveolar maxillary hypoplasia
M26.74	Alveolar mandibular hypoplasia
M26.79	Other specified alveolar anomalies
M26.81	Anterior soft tissue impingement
M26.82	Posterior soft tissue impingement
M26.89	Other dentofacial anomalies
M26.9	Dentofacial anomaly, unspecified
M27.0	Developmental disorders of jaws
Q67.4	Other congenital deformities of skull, face and jaw
Q35.1	Cleft hard palate
Q35.3	Cleft soft palate
Q35.7	Cleft uvula
Q36.0	Cleft lip, bilateral
Q36.9	Cleft lip, unilateral
Q37.0	Cleft hard palate with bilateral cleft lip
Q37.1	Cleft hard palate with unilateral cleft lip
Q37.2	Cleft soft palate with bilateral cleft lip
Q37.3	Cleft soft palate with unilateral cleft lip
Q37.4	Cleft hard and soft palate with bilateral cleft lip
Q37.5	Cleft hard and soft palate with unilateral cleft lip

5. DEFINITIONS:

Cleft Lip: A congenital facial defect of the lip due to failure of fusion of the medial and lateral nasal prominences and maxillary prominence.

Cleft Palate: A congenital fissure in the medial line of the palate.

Comprehensive Orthodontic Treatment: A coordinated approach to improvement of the overall anatomic and functional relationships of the dentofacial complex, as opposed to partial correction with more limited objectives such as cosmetic improvement. Usually but not necessarily uses fixed orthodontic attachments as a part of the treatment appliance. Includes treatment and adjunctive procedures, such as extractions, maxillofacial surgery, other dental services, nasopharyngeal surgery, and speech therapy, directed at mal-relationships within the entire dentofacial complex.

Craniofacial Anomaly: A structural or functional abnormality that affects the cranium or face.

Handicap (as Related to Handicapping Malocclusion): A physical, mental, or emotional condition that interferes with one's normal functioning.

Malocclusion (as Related to Handicapping Malocclusion): A problem in the way the upper and lower teeth fit together in biting or chewing. The word malocclusion literally means "bad bite." The condition may also be referred to as an

irregular bite, crossbite, or overbite.

Orthodontic Retention: The process of removal of all orthodontic treatment appliances, the construction of retainer(s), and the placement of retainer(s) to stabilize the occlusion and prevent treatment relapse.

ODM Form 03630: A method for measuring malocclusion that provides a single score representing the degree to which a case deviates from normal alignment and occlusion.

Overbite: When the upper front teeth reach too far down over the lower front teeth and, in severe cases, can cause the lower teeth to bite into the roof of the mouth.

Overjet: When the top teeth extend past the bottom teeth horizontally, measured only from the maxillary central incisors.

Periodic Orthodontic Treatment Visit: A scheduled orthodontic appointment to monitor progress of orthodontic treatment, make necessary adjustments to brackets and/or bands, wires, appliances, or aligners, and evaluate the health of the teeth, soft tissue, and supporting alveolar bone.

Reviews, Revisions, and Approvals	Date	Approval Date
New Policy	01/2026	01/2026

6. References

a. American Dental Association. CDT 2025: Dental Procedure Codes. American Dental Association, 2025.

b. State Use of an Orthodontic Index, Medicaid|Medicare|CHIP Services Dental Association, May 2016 Available at http://www.msdanationalprofile.com/2015-profile/policy-and-benefits/orthodontic-medical-necessity/?

c. AAO Leads Effort to Establish Consistency on Medically Necessary Orthodontic Care, American Association of Orthodontists News July 2015. Available at https://www.aaoinfo.org/news/2015/07/aao-leads-effort-establish-consistency-medically-necessary-orthodontic-care

d. American Association of Orthodontists Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics 2014. Available at: https://www.aaoinfo.org/system/files/media/documents/2014%20Cllinical%20Practice%20Guidelines.pdf

e. American Association of Orthodontists Guidance on Medically Necessary Orthodontic Care 2019.

f. American Dental Association. CDT 2025 Coding Companion

g. Validity and Reliability of HLD Treatment Need Indices Currently Used in the United States. Timothee Cousins, University of Washington, 2021. Available at: https://digital.lib.washington.edu/researchworks/bitstreams/d72b5488-4eb0-4ff8-825c-049203283821/download

h. Commonwealth of Massachustetts HLD Form and excerpts from Commonwealth Fair Hearings. Available at: https://provider.bluecrossma.com/ProviderHome/wcm/connect/e8825d8f-37a4-468c-87a5-b09a99c5c7ea/MPC_101218-2T_Orthodontic+HLD+Form.pdf?MOD=AJPERES

i. Commonwealth of Massachusetts Fair Hearing decision noting ambiguity in measuring overjet. Available at: https://www.mass.gov/doc/appeal-2112351/download

j. State of California HLD Form. Available at: https://dental.dhcs.ca.gov/MCD_documents/providers/DC016.pdf

7. Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of dental practice; peer-reviewed

dental/medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national dental and health professional organizations; views of dentists practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. Managed Care Plans (MCP) make no representations and accept no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of dental practice current at the time that this clinical policy was approved. MCP means a health/medical plan that has adopted this clinical policy and that operates or administers, in whole or in part, directly or indirectly through a dental plan administrator, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable MCP administrative policies and procedures.

This clinical policy is effective as of the date determined by ODM. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. ODM retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute dental or medical advice, dental treatment or dental care. It is not intended to dictate to providers how to practice dentistry. Providers are expected to exercise professional dental and medical judgment in providing the most appropriate care and are solely responsible for the dental and medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating dentist in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom MCPs have no control or right of control. Providers are not agents or employees of the MCPs.

B. D8220 Fixed Appliance

1. Definition
    a. Fixed appliance therapy refers to a passive appliance that cannot be removed by the patient intended to break a harmful habit that may impact the growth or development of a patient
2. Applicable CDT Codes
    a. D8220 - Fixed appliance therapy
3. Clinical Indications
    a. Parafunctional habits including but not limited to thumb sucking and tongue thrusting
4. Documentation Required
    a. Prior authorization required, submit:
        i. Diagnostic models or photographs of the mouth
        ii. Narrative of medical necessity

5. Limitations
    a. Excludes treatment for bruxism or TMD
6. Other Clinical Considerations
    a. Medical necessity determination based on other circumstances will be required in the absence of any of the above clinical criteria
7. Administrative Considerations

C. D8999 Unspecified Orthodontic Procedure

1. Definition
    a. Unspecified orthodontic procedure is used to report a procedure not adequately described by an existing covered or non-covered code
2. Applicable CDT Codes
    a. D8999 - Unspecified orthodontic procedure, by report
3. Clinical Indications
    a. Any procedure not adequately described by an existing covered or non-covered code
4. Documentation Required
    a. Prior authorization required, submit:
        i. Narrative of medical necessity
        ii. Any other documentation or radiographs needed to show medical necessity
    b. Note: Radiographs should be unaltered by AI. AI radiographs may be submitted as adjunctive documentation only
5. Limitations – None
6. Other Clinical Considerations
    a. Medical necessity must be adequately documented for coverage consideration
7. Administrative Considerations – None

Disclaimer: Mail-Order Orthodontic Aligners

Liberty does not consider mail-order orthodontic aligner kits to be a covered benefit. Therefore, Liberty will not reimburse providers or members for purchasing mail-order orthodontic kits.

Rationale- Orthodontic benefits are payable only for services performed by a licensed dentist. This requirement is imposed primarily for member protection, as it ensures that any procedures performed are necessary, appropriate and delivered within the standards of good dental practice. In the case of many mail order aligner kits, a dentist does not physically examine or oversee the patient care as he or she self-administers a series of orthodontic aligners at home. It is especially important that a dentist monitor that patient during orthodontic treatment, since refinements, revisions and adjustments of aligners are expected and very common. A dentist has the ability and requisite training to properly monitor treatment progress, which is imperative in orthodontic treatment.

Liberty HLD Form 03630

Ohio Department of Medicaid

EVALUATION FOR COMPREHENSIVE ORTHODONTIC TREATMENT

Last Name	First Name	Medicaid ID Number	Date of Birth

Cases must be considered, reviewed, and approved on a case-by-case basis. Generally, comprehensive orthodontic care (D8080) will require management of all permanent teeth except 3rd molars and as a guideline can begin for females at age 10 years and males at 12 years or if all permanent teeth except 2nd molars are at least partially present unless missing or impacted. This will allow for adequate treatment time for growth modification, if necessary, and control of all permanent teeth.

PROCEDURE (use this score sheet and a Boley Gauge or disposable ruler):

- **Indicate by checkmark next to A, B, or C, which criteria you are submitting for review**
- Position the patient's teeth in centric occlusion for photos and cephalometric radiographs with the lips relaxed for both
- Record all measurements in the order given and round off to the nearest millimeter (mm)
- ENTER SCORE "0" IF CONDITION IS ABSENT IN SECTION B

CONTINUE TO SECTION BELOW AND SCORE ALL PRESENT CONDITION

A. ☐	**CONDITIONS 1-7 ARE AUTOMATIC QUALIFIERS** (place "X" if present)	Provider	Plan Only
1.	Overjet: greater than 9.0 mm	☐	☐
2.	Reverse overjet: greater than 3.5 mm	☐	☐
3.	Anterior crossbite of 2 or more teeth with evidence of gingival recession	☐	☐
4.	Impinging overbite – tissue laceration and/or clinical attachment loss must be present	☐	☐
5.	Anterior impactions where eruption is impeded but extraction is not indicated	☐	☐
6.	Jaws and/or dentition which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma, or pathology	☐	☐
7.	Crowding greater than 8.0 mm in maxillary arch only	☐	☐

B. ☐	**CONDITIONS 8-9 19 MUST SCORE 22 POINTS OR MORE TO QUALIFY**	Provider		Plan Only
1.	**Overjet** (measurement must be greater than 2 mm – see instructions on page 2)	mm_____	x	1=_____
2.	**Overbite** (measurement must be greater than 2 mm – see instructions on page 2)	mm_____	x	1=_____
3.	**Mandibular protrusion** (reverse overjet, **"underbite"** – see instructions on page 2)	mm_____	x	5=_____
4.	**Anterior open bite** (do not count ectopic teeth – see instructions on page 2)	mm_____	x	4=_____
5.	**Ectopic teeth** (excludes 3rd molars) # teeth (score 0 if crowding is claimed)	#_____	x	3=_____
6.	**Congenitally missing posterior teeth** (excluding third molars)	#_____	x	3=_____
7.	**Anterior crowding of maxilla** (greater than 3.5 mm) if present score as 5			5=_____
8.	**Anterior crowding of mandible** (greater than 3.5 mm) if present score as 5			5=_____
9.	**Labio-lingual spread** (either measure a displaced tooth from the normal arch form, the labial-lingual distance between adjacent anterior teeth, or the anterior mesio-distal spacing between adjacent anterior teeth – see rules on page 2)	mm_____	x	1=_____
10.	**Posterior crossbite** (2 or more teeth – 1 must be a molar), score only once as 4			4=_____
11.	**Posterior impactions (**see scoring rules on page 2, excludes 3rd molars)	#_____	x	3=_____

12.	**Psychiatrist/psychologist/speech therapist-diagnosed condition** (instructions on page 2)		x	10=_____
TOTAL SCORE (must score 22 points or more to qualify)		_____		_____

C. ☐ **Other reason to consider orthodontic case** *(see provider notes)*			
Provider Signature *(Provider attests to the accuracy stated above)*			Date
First Name	Last Name	NPI Number	Phone Number

Other Conditions and Provider Notes

Plan Only Notes

INSRTUCTIONS FOR COMPLETING ODM 03630 SCORING FORM

The provider is encouraged to score the case and exclude any case that obviously would *not* qualify for treatment. Upon completion of the Form 03630 score sheet, review all measurements and calculations for accuracy.

1. Indicate by checkmark next to Section A, B, or C to indicate which criteria you are submitting for review.
2. Position the patient's teeth in centric occlusion for lateral and frontal intraoral photographic images.
3. Record all measurements in the order given and round off to the nearest millimeter (use a ruler to show measurements).
4. Enter the score of "0" for section elements in the B Section if using Section B to qualify and the condition is absent.

A. CONDITIONS 1 - 7 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present)

B. CONDITIONS 8 - 19 MUST SCORE 22 POINTS OR MORE TO QUALIFY

8. **Overjet –** this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of the lower incisor to the incisal edge of upper incisor. Measure parallel to the occlusal plane. Only use central incisors. The measurement may apply to only one (1) tooth if it is severely protrusive. Do *not* record overjet and mandibular protrusion (reverse overjet) on the same patient. Enter measurement if greater than 2 mm and multiply by one (1).
9. **Overbite –** a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking and use the incisal edge of one of the upper central incisors. Do *not* use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edge to the pencil mark. "Reverse" overbite may exist and should be measured on an upper central incisor - from the incisal edge to the pencil mark. Do *not* record overbite and open bite on the same patient. Enter measurement if greater than 2 mm and multiply by one (1).
10. **Mandibular (dental) protrusion or reverse overjet –** measured from the labial surface of the upper incisor to the incisal edge of the lower incisor. Measure parallel to the occlusal plane. Only use central incisors for this measurement. Do *not* record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement is entered on the score sheet and multiplied by five (5).
11. **Open bite –** measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. Do *not* record overbite and open bite on the same patient. The measurement is entered on the score sheet and multiplied by four (4).
12. **Ectopic eruption* –** Refers to an unusual pattern of eruption, such as a high canine. Count each tooth excluding third molars. Enter the number of teeth and multiply by three (3). If anterior crowding of either arch is claimed, ectopic.
13. **Congenitally missing posterior teeth** – excluding third molars. Enter number of teeth and multiply by three (3).
14. **Anterior crowding of maxilla*** – anterior arch length insufficiency *must* exceed 3.5 mm. Score only fully erupted incisors and canines. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point fora maxillary arch with anterior crowding and multiply by five (5).
15. **Anterior crowding of mandible*** – anterior arch length insufficiency *must* exceed 3.5 mm. Score only fully erupted incisors and canines. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for mandibular arch with anterior crowding and multiply by five (5).

16. **Labio-lingual spread** – use a measurement tool is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. If multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the index. Additionally, anterior spacing may be measured as the total score in mm of the spacing from the mesial of the canine to the mesial of the opposite canine, totaling both arches. Score only the greater score attained by either of these two methods and multiply by one (1).

17. **Posterior crossbite** – this condition involves two (2) or more posterior teeth, one (1) of which *must* be a molar. The crossbite *must* be one in which the maxillary posterior teeth involved may be palatal to normal relationships or completely buccal to the mandibular posterior teeth. The presence of posterior crossbite is indicated by a score of four (4) on the score sheet.

18. **Posterior impactions** – where eruption is impeded but extraction is not indicated, excluding third molars. Enter number of teeth and multiply by three (3).

19. **A) Psychosocial Injury Cases**** – Patient experiences clinically significant distress or impaired psychosocial functioning substantially contributed to by the patient's malocclusion. This is supported by a diagnosis verified with documentation from a psychologist or psychiatrist following a screening examination or interview. Score as 10; or,

    B) Speech Impairment Cases** – Patient experiences significant speech impairment which is diagnosed as a speech or language pathology caused by the patient's malocclusion. This is verified with documentation from a speech therapist following a screening evaluation or interview. Score as 10.

    *** Either ectopic eruption or anterior crowding in the same arch may be counted, but not both.**

    **** 19.A or 19.B (not both)** must be combined with scored conditions: **19A** with points from 8, 10, 11, 12, 14, and 16; **OR 19B** with points from 8, 10, 11, 16, and 17 for total scoring.

C. Other reason to consider orthodontic case – enter reason(s) in provider notes section.