DELTA DENTAL®

VERMONT HEALTH CONNECT CRITERIA FOR MEDICALLY NECESSARY ORTHODONTIA
Delta Dental Plan of Vermont

Qualifications for orthodontic benefits to correct handicapping malocclusions must include either one (1) of the Major Diagnostic Criteria, or two (2) of the Minor Diagnostic Criteria as listed below:

Major Diagnostic Criteria:

- Cleft palate
- Two (2) impacted cuspids
- Posterior crossbite of three (3) or more teeth
- Severe craniofacial syndrome (Treacher-Collins syndrome, Marfan syndrome, Pierre Robin syndrome, etc.)

Minor Diagnostic Criteria:

- One (1) impacted cuspid
- Two (2) blocked cuspids
- Three (3) congenitally missing teeth
- Open bite of four (4) or more teeth
- Crowding
- Anterior crossbite of three (3) or more teeth
- Traumatic deep bite impinging on palate
- Overjet of 8 mm

Clinical Documentation Requirements for Consultant Review

- Prior Authorization Form (Orthodontic Form for Medical Necessity)
- Summary of the treatment plan, including the length of treatment; must be legible
- Diagnostic photographic prints to include lateral and occlusal views, and radiographs
    - Prints must be exposed with the patient's face clearly discernible
    - Mount photographic prints in clear plastic mounts, indicating the dentist and patient names, and the date of the prints
- ADA Claim Form

Prior Authorization is required for all Medically Necessary Orthodontic treatment. Please complete and submit a claim form and the following Prior Authorization form, along with the clinical documentation requested. Should you have any questions, please call Northeast Delta Dental Professional Relations at 1-800-537-1715, and ask to speak with one of our dental consultants.

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Orthodontic Form for Medical Necessity

DELTA DENTAL PLAN OF VERMONT

All pages of this form must be completed and submitted for prior authorization BEFORE treatment.

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. TREATMENT REQUESTED (Check box below)

☐ Case Study Only ☐ Full Treatment ☐ Interceptive Treatment ☐ Limited Transitional Treatment ☐ Transfer Case (If checked, indicate months required to complete treatment

TENTATIVE TREATMENT PLAN:

FUNCTIONAL CONCERNS:

Are you considering Orthognathic Surgery? ◯ Yes ◯ No
If yes, please explain:

(There should be no other equally effective, more conservative, and substantially less costly treatment available).

Orthodontic Diagnostic Information

PART I

STAGE OF DENTITION:

☐ Primary ☐ Permanent ☐ Mixed

ANTERIOR TEETH:

	Overjet		mm	
	Overbite		mm	
	Open Bite		mm	
	Midline		mm	

Cross-bite:
Indicate teeth involved: _____

Deep bite impinging on palate:
Indicate teeth involved: _____

POSTERIOR TEETH:

Angle Classification:

Skeletal Classification: (Check One)
☐ Class 1 ☐ Class 2 ☐ Class 3

Dental Classification: (Check One)
Right ☐ Class 1 ☐ E to E ☐ Class 2 ☐ Class 3
Left ☐ Class 1 ☐ E to E ☐ Class 2 ☐ Class 3

Cross-bite:
Indicate teeth involved: _____

BRIEF INITIAL OPINIONS

CLIENT'S CHIEF COMPLAINT

HABITS

MUSCULATURE: TONE AND FUNCTION:

SYMMETRY OF ARCHES:

ANTERIOR CROWDING (Approximate)			SPACING		
MAX	mm		MAX	mm	
MAND	mm		MAND	mm	

TEMPOROMANDIBULAR DYSFUNCTION:

MISSING TEETH (List)

ORAL HYGIENE:
◯ Good ◯ Fair ◯ Poor

	Yes	Tooth/Location
Ectopic Eruption (Numbers of teeth excluding third molar(s):	☐	
Missing (indicate teeth):	☐	
Impacted cuspids:	☐	
Blocked cuspids:	☐	
Ankylosed (indicate teeth):	☐	
Supernumerary (indicate location):	☐	

RESTORATION OR CARIES PROBLEMS:

OTHER MEDICAL OR DENTAL PROBLEMS:

PART II.

PLEASE INDICATE IF PATIENT HAS FOLLOWING MEDICAL CONDITION(S) OR CRANIOFACIAL ANOMALIES WHICH AUTOMATICALLY QUALIFIES:

Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement	☐
Treacher Collins syndrome	☐
Pierre Robin syndrome	☐
Marfan syndrome	☐
Other Craniofacial anomalies (please describe)	☐

PLEASE NOTE: This form is a guideline for your use and reference. You will still be required to send all required information for prior authorization. Delta Dental 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.

PRINT NAME Examination Completed by:	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 (INCLUDE CREDENTIALS)	PRINT NAME	DATE

Instructions for Completing the Vermont Orthodontic Form for Medical Necessity

The intent of this index is to record the presence or absence, and the degree, of the handicap for the patient and not to diagnose "malocclusion". All measurement are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. The following information should help clarify the categories used in this index:

1. The following conditions if they exist are considered by Vermont Health Connect to be Major Diagnostic Criteria and are automatically qualifying:

    - Cleft palate
    - Two (2) impacted cuspids
    - Posterior crossbite of three (3) or more teeth
    - Severe craniofacial syndrome (Treacher-Collins syndrome, Marfan syndrome, Pierre Robin syndrome, etc.)

2. Severe Traumatic Deviations may also qualify a patient for medically necessary orthodontic treatment: Traumatic deviations are, for example, loss of premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology.

3. Patients who exhibit two or more of the following Minor Diagnostic Criteria may also qualify the patient for approval:

    - One (1) impacted cuspid
    - Two (2) blocked cuspids
    - Three (3) congenitally missing teeth
    - Open bite of four (4) or more teeth
    - Crowding
    - Anterior crossbite of three (3) or more teeth
    - Traumatic deep bite impinging on palate
    - Overjet of 8 mm or more

4. The following measurements and conditions may be submitted to support prior authorization for medically necessary orthodontics. Record all measurements millimeters:

    - **Overjet:** Measure patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper 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 index form.

    - **Overbite:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter. "Reverse" overbite may exist in certain conditions and should be measured and recorded.

    - **Mandibular Protrusion:** Record exactly as measured from the labial of the lower incisor to the labial of the upper incisor.

    - **Open Bite:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters. 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.

    - **Blocked Teeth (Ectopic Eruption):** Count each tooth, excluding third molars. 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% blocked out and clearly out of the dental arch. Regarding mutually blocked out teeth, only one will be counted.

    - **Anterior Crowding:** Record arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not considered to be crowded.

    - **Labiolingual Spread:** A Boley Gauge (or a disposable ruler) 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 the tooth's normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labiolingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. In the advent that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labiolingual spread, only the most severe individual measurement should entered on the index.

    - **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.