Delta Dental of North Carolina

Medically Necessary Orthodontia
Benefit Guidelines

Directions For Submitting Medically Necessary Orthodontic Claims

All orthodontic procedures require pre-treatment evaluation for coverage under your patient's dental plan.
Orthodontic services are only covered benefits of the dental plan when the patient's condition meets the State of North Carolina criteria for coverage of orthodontics, i.e., severe malocclusions caused by craniofacial anomalies like cleft lip and palate or other conditions caused by a syndrome (see the NC Division of Medical Assistance Clinical Coverage Policy No: 4B, NCHC Specific Criteria, at http://www2.ncdhhs.gov/dma/mp/2ortho.pdf).

Please submit this Orthodontic Service Coverage Evaluation Form with the applicable information filled in (see the instructions for filling out the form on the form's pages 2-3) and attach the following information:

- Physical evidence of a handicapping malocclusion defined by pre-orthodontic study models and radiographic/photographic imaging including panoramic/cephalometric images and any associated tracings (radiographs and photographs must be of diagnostic quality);
- A detailed description of the functional impairment(s) considered to be the direct result of the handicapping malocclusion;
- Patient treatment records from the treating dentist/orthodontist documenting evaluation, diagnosis and any previous treatment provided to manage the functional impairment(s); and
- The treating dentist's/orthodontist's plan of care documenting proposed procedures to manage the patient's condition including the expected outcome for the improvement of the functional impairment(s).

All documents must be received to accurately determine if the case qualifies for medically necessary benefits. Please note that we cannot return orthodontic models. Please make two sets of models and send us the duplicate set.

We recommend that orthodontic treatment not be started prior to receiving notification from us indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin orthodontic treatment before receiving an approved or denied pre-treatment estimate will be responsible for collecting the fee from the party responsible for the patient if the patient does not meet the criteria for coverage. Once a case has been denied, you cannot resubmit for consideration unless there has been a significant change in the patient's occlusion which would qualify the patient for treatment of a handicapping malocclusion.

The completed Orthodontic Service Coverage Evaluation Form and the additional requested information/materials must be sent to Delta Dental in order for the orthodontic claim that you have submitted to be processed.

Please submit the form and requested information/materials to:

Delta Dental Plan of Michigan
Attn: Professional Review
P. 0. Box 30416
Lansing, Ml 48909-7916

Orthodontic Service Coverage Evaluation Form (Modified Handicapping Labio-Lingual Deviation Evaluation Index)

See Pages 2-3 For Instructions On Filling Out This Form.

See The Attached "Directions On Submitting Orthodontic Claims" Sheet For Documentation Requirements.

Patient Name (Last, First, MI)	**Member ID**	**Date Of Birth**
Treating Dentist's Name		**Date Of Orthodontic Assessment**

PART 1	**Does Your Patient Have Any Of The Following Conditions?** *Circle "X" if your patient has the condition and "0" if your patient does not have the condition.*		
	Presence of cleft lip and/or palate (please include documentation of the condition).	**X**	**0**
	Handicapping malocclusion caused by craniofacial anomalies (please include documentation of the condition).	**X**	**0**
	Deep impinging overbite with either palatal trauma or mandibular anterior gingival trauma, i.e., when clinical attachment loss and recession of the gingival margin are present (please include photos documenting tissue damage).	**X**	**0**
	Crossbite of individual anterior teeth with evidence of clinical attachment loss and/or recession of the gingival margin (please include photos documenting tissue damage).	**X**	**0**
	Severe traumatic deviation, e.g., loss of a premaxilla segment due to accident or pathology (please include documentation of the condition).	**X**	**0**
	Severe anterior-posterior occlusal discrepancy with an overjet equal to or greater than 9 millimeters or a reverse/negative overjet equal to or greater than 3.5 millimeters.	**X**	**0**
	Impacted permanent anterior teeth which are contributing to a handicapping malocclusion.	**X**	**0**
	Posterior crossbite involving multiple posterior teeth with no functional occlusal contact.	**X**	**0**
	Anterior open bite equal to or greater than 4 mm (where incisors have fully erupted and the discrepancy is not correctable by habit therapy).	**X**	**0**
	Lateral open bite equal to or greater than 4 mm.	**X**	**0**
	Congenitally missing teeth (extensive hypodontia) excluding third molars.	**X**	**0**

STOP Filling Out This Form Here If You Have Circled One Or More "X" Above – Otherwise Continue To Parts 2 And 3

PART 2	**Please Fill In The Following Overjet/Overbite/Open Bite Information For Your Patient** (leave blank if not applicable)		
	Overjet in millimeters if equal to or less than 9 millimeters	mm	
	Overbite in millimeters	mm	
	Mandibular protrusion (reverse overjet) in millimeters if equal to or less than 3.5 millimeters	mm	**X 5 =**
	Open bite in millimeters	mm	**X 4 =**

PART 3	**Please Fill In The Following Ectopic Eruption/Crowding Information For Your Patient** (leave blank if not applicable)			
If both anterior crowding and ectopic eruption are present in the anterior portion of the mouth, provide information for only the *most severe condition*. Do *not* score both conditions.				
Ectopic eruption (exclude 3rd molars) *Identify by tooth number and count each tooth*	▲ List Ectopically Erupted Teeth Numbers		▲ Total # Of Teeth	**X 3 =**
Anterior crowding (2 points maximum) *If upper crowding present, score one point for MAXILLA* *If lower crowding present, score one point for MANDIBLE*	▲ Maxilla (0 or 1)	▲ Mandible (0 or 1)	▲ Add For Total (0, 1 or 2)	**X 5 =**
Labio-lingual spread in millimeters				mm
Posterior unilateral crossbite (involving at least one molar) *Circle Yes Or No*			Yes **4**	No **0**
Total Score				

Instructions Start On The Next Page

Orthodontic Service Coverage Evaluation Form Instructions

General Instructions

The intent of the Orthodontic Service Coverage Evaluation Form is to document the presence or absence and the degree of any handicap caused by the one or more of the conditions on the form. All measurements should in millimeters (round up to the nearest millimeter).

Part 1: Identification Of Conditions Considered To Be A Handicapping Malocclusion

The presence of any of the listed conditions should be recorded by circling the "X" in the left-hand column. The absence of any of the conditions must be recorded by circling the "0" in the right-hand column. The following information is provided to help clarify the conditions:

Cleft Palate Deformities: If your patient has this condition, circle the "X" on the evaluation form and do not fill in the form any further. Documentation must include photographs and a written report from a qualified specialist(s) treating the deformity.

Cranio-Facial Anomaly: If your patient has this condition, circle the "X" on the evaluation form and do not fill in the form any further. Documentation must include photographs and a written report from a qualified specialist(s) treating the anomaly.

Deep Impinging Overbite With Severe Soft Tissue Damage: This condition is present when the lower incisors are destroying the soft tissue of the palate or the lower anterior gingiva. Tissue laceration, maceration and/or clinical attachment loss must be present. If your patient has this condition, circle the "X" on the evaluation form and do not fill in the form any further.

Crossbite Of Individual Anterior Teeth: This condition is present when clinical attachment loss and recession of the gingival margin are present. Circle the "X" on the evaluation form when destruction of soft tissue is present and do not fill in the form any further.

Severe Traumatic Deviations: Traumatic deviations include loss of a premaxilla segment by burns or by accident, the result of osteomyelitis or other gross pathology. If your patient has this condition, circle the 'X" on the evaluation form and do not fill in the form any further. Include a written report and photographs.

Overjet Greater Than 9 Millimeters Or Mandibular Protrusion (Reverse Overjet) Is Greater Than 3.5 Millimeters: This condition is present when 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 your patient has this condition, circle the "X" on evaluation form and do not fill in the form any further. If the reverse overjet is not greater than 3.5mm, fill in the information for your patient under the "Mandibular Protrusion in Millimeters" item in Part 2 (third line).

Impacted Permanent Anterior Teeth: Demonstrate that one or more anterior teeth (i.e., incisors and/or cuspids) which are contributing to a handicapping malocclusion are (1) impacted (soft or hard tissue), (2) exposure and passive eruption is unlikely, (3) extraction would compromise the integrity of the arch, (4) the teeth are treatment planned to be exposed, ligated/banded and brought into the normal arch form and (5) there is, or will be, sufficient arch space for correction. If your patient has this condition, circle the 'X" on the evaluation form. If your patient does not have this condition, circle the "0" on the evaluation form.

Posterior Crossbite Involving Multiple Posterior Teeth With No Functional Occlusal Contact: If your patient has this condition, circle the 'X" on the evaluation form. If your patient does not have this condition, circle the "0" on the evaluation form.

Anterior Open Bite Equal To Or Greater Than 4 Millimeters: This condition exists where incisors have fully erupted and the discrepancy is not correctable by habit therapy. If your patient has this condition, circle the 'X" on the evaluation form. If your patient does not have this condition, circle the "0" on the evaluation form.

Lateral Open Bite Equal To Or Greater Than 4 Millimeters: This condition exists where there are congenitally missing teeth (extensive hypodontia) with at least one tooth missing per quadrant (excluding third molars). If your patient has this condition, circle the 'X" on the evaluation form. If your patient does not have this condition, circle the "0" on the evaluation form.

Instructions Are Continued On The Next Page

Part 2: Overjet/Overbite/Open Bite Information

Overjet Equal To Or Less Than 9 Millimeters: This measurement 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 incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. Round this measurement to the nearest millimeter and enter on the evaluation form.

Overbite In Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. Round off to the nearest millimeter and enter on the evaluation form. "Reverse" overbite may exist in certain conditions and should be measured and recorded.

Mandibular Protrusion (Reverse Overjet) Equal To Or Less Than 3.5 Millimeters: Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. The measurement in millimeters is entered on the evaluation. A reverse overbite, if present, should be shown under "overbite."

Open Bite In Millimeters: This condition is defined as the absence of incisal contact in the anterior region. It is measured from edge to edge in millimeters. Enter the measurement on the evaluation form. 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.

Part 3: Ectopic Eruption And Crowding Information

Ectopic Eruption: Count each tooth, excluding third molars. Each qualifying tooth must be more than 50% blocked out of the arch. Enter the number of teeth on the evaluation form. If anterior crowding is present with an ectopic eruption in the anterior portion of the mouth, record only the most severe condition. DO NOT SCORE BOTH CONDITIONS. However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

Anterior Crowding: Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be recorded on the evaluation form as crowded. Enter 1 point each for maxillary and mandibular anterior crowding. If ectopic eruption is also present in the anterior portion of the mouth, score the most severe condition. DO NOT SCORE BOTH CONDITIONS. Posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

Labio-Lingual Spread: This measurement is to record the extent of deviation from a normal arch form on the evaluation form. 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 anterior tooth and the most lingually displaced anterior tooth is measured. The labio-lingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labiolingual spread, but only the most severe individual measurement should be 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 either be both palatal or both completely buccal in relation to mandibular posterior teeth. Circle "Yes" if your patient has a posterior unilateral crossbite. If you patient has a bi-lateral crossbite or no crossbite, circle "No".