

**NEW HAMPSHIRE CRITERIA FOR MEDICALLY NECESSARY  
ORTHODONTIC SERVICES IN THE PEDIATRIC DENTAL BENEFIT  
Delta Dental Plan of New Hampshire**

“Medically Necessary Orthodontic Services,” as defined by the State’s dental benchmark plan, means orthodontic services to help correct severe handicapping malocclusions caused by craniofacial orthopedic deformities involving the teeth. Examples of conditions causing such deformities include, but are not limited to, cleft palate, Treacher-Collins syndrome, Pierre-Robin syndrome, Marfan syndrome and Crouzon syndrome. Such conditions often require a combined pre- or post-orthognathic surgery/orthodontic treatment approach.

**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’s and patient’s names, and the date of the prints
- ADA Claim Form
- Any other medical or dental information that will assist us in making an authorization

**Prior authorization is required for all Medically Necessary Orthodontic treatment.** Please complete and submit a claim form and the following Orthodontic Form for Medical Necessity, along with the clinical documentation listed above. This form includes the Handicapping Labio-Lingual Deviations (HLD) index. The HLD provides a single score based on a series of measurements that represent the degree to which a case deviates from normal alignment and occlusion. All forms must be legible. 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.

## HANDICAPPING LABIOLINGUAL INDEX SCORING INSTRUCTIONS FOR SEVERE MALOCCLUSION

The intent of the HLD Index is to record 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 Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering "O" (refer to score sheet).

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

1. **Deep Impinging Overbite:** Indicate an "X" on the score sheet when lower incisors are destroying the soft tissue of the palate. If you mark an "X" here, do not score any further. This condition is automatically considered a handicapping malocclusion, and no further scoring is necessary.
2. **Impacted Permanent Anterior Teeth:** Document permanent cuspids that are impacted; exposure and passive eruption is unlikely; extraction would compromise the integrity of the arch; and, the teeth are treatment planned to be exposed ligated/banded and brought into the normal arch form; and there is, or will be, sufficient arch space for correction. If two impacted permanent cuspids are present, indicate an "X" on the score sheet and do not score any further. If one impacted permanent cuspid is present, the score is 13.
3. **Crossbite of Individual Anterior Teeth:** Indicate an "X" on the score sheet when destruction of soft tissue is present. If you mark an "X" here, do not score any further. This condition is automatically considered a handicapping malocclusion and no further scoring is necessary.
4. **Severe Traumatic Deviations:** Traumatic deviations are, for example, loss of premaxilla segment by trauma, the result of osteomyelitis, syndromes, or other gross pathology. Indicate with an "X" on the score sheet and attach documentation and description of condition. If you mark an "X" here, do not score any further. This condition is automatically considered a handicapping malocclusion, and no further scoring is necessary.
5. **Overjet greater than 9 mm:** If the overjet is greater than 9 mm with incompetent lips or the reverse overjet (mandibular protrusion) is greater than 3.5mm with reported masticatory and speech difficulties, indicate an "X" and score no further. If the reverse overjet is not greater than 3.5 mm, score under #6.
6. **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 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 score sheet.
7. **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 score sheet. "Reverse" overbite may exist in certain conditions and should be measured and recorded.
8. **Mandibular Protrusion in 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 score sheet and multiplied by five (5). A reverse overbite, if present, should be shown under "overbite."
9. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). 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.
10. **Ectopic Eruption:** Count each tooth, excluding third molars. Enter the number of teeth on the score sheet and multiply by three (3). If condition #11, 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 in other locations other than in the dental arch. 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.*
11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter five (5) points each for maxillary and mandibular anterior crowding. If condition #10, ectopic eruption is also present in the anterior portion of the mouth, score the most severe condition. **Do not score both conditions.**
12. **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. If multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labiolingual spread, with only the most severe individual measurement entered on the form.
13. **Posterior Unilateral Crossbite:** This condition involves two or more adjacent teeth, one of which must be a permanent 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 four (4) on the score sheet.



# Orthodontic Form for Medical Necessity

DELTA DENTAL PLAN OF NEW HAMPSHIRE

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   
 Interceptive Treatment   
 Transfer case (If checked, indicate months required to complete treatment)
- Limited Full Treatment   
 Transitional 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 II.

STAGE OF DENTITION:				BRIEF INITIAL OPINIONS			
<input type="checkbox"/> Primary <input type="checkbox"/> Permanent <input type="checkbox"/> Mixed				CLIENT'S CHIEF COMPLAINT:			
ANTERIOR TEETH:				HABITS:			
Overjet		mm					
Overbite		mm					
Open bite		mm					
Midline		mm					
<u>Cross-bite:</u> Indicate teeth involved: _____				MUSCULATURE TONE AND FUNCTION:			
POSTERIOR TEETH: Angle Classification: Skeletal Classification: (Check One) <input type="checkbox"/> Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 Dental Classification: (Check One) Right <input type="checkbox"/> Class 1 <input type="checkbox"/> E to E <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 Left <input type="checkbox"/> Class 1 <input type="checkbox"/> E to E <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 Cross-bite: Indicate teeth involved: _____				SYMMETRY OF ARCHES:			

**PART IV. HANDICAPPING LABIOLINGUAL DEVIATION INDEX (HLD). See HLD scoring instructions regarding on page 2.**

HANDICAPPING LABIOLINGUAL DEVIATION INDEX (HLD)	HLD SCORE	
1. Deep impinging overbite WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE. (Indicate an "X" if present and score no further.)	____ X 26	
2. Each Impacted Permanent Cuspid: (If two are present, indicate an "X" and score no further.)	____ X 13	
3. Cross bite of three or more anterior teeth. (Indicate an "X" if present and score no further.)	____ X 26	
4. Severe traumatic deviations. For example, loss of a premaxilla segment by trauma, the result of osteomyelitis, syndromes, or other gross pathology. (Indicate an "X" if present and score no further.)	____ X 26	
5. Overjet greater than 9mm WITH INCOMPETENT LIPS OR REVERSE OVERJET GREATER THAN 3.5 MM WITH REPORTED MASTICATORY AND SPEECH DIFFICULTIES. (Indicate an "X" if present and score no further.)	____ X 26	
6. Overjet in mm.	____ X 3	
7. Overbite in mm.	____ X 1	
8. Mandibular protrusion in mm.	____ X 5	
9. Openbite. (Greater than 4 teeth)	____ X 4	
<b>If both ectopic eruption (#10) and anterior crowding (#11) are present in the anterior portion of the mouth, score only the most severe condition. Do NOT score both conditions.</b>		
10. Ectopic eruption: Count each tooth excluding 3 <sup>rd</sup> molars.	____ X 3	
11. 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	
12. Labiolingual spread in mm.	____ X 1	
13. Posterior unilateral cross bite (must involve three or more adjacent teeth, one of which must be a molar). If present, score 4.	____ X 4	
<b>PROVIDER ESTIMATED TOTAL HLD SCORE</b>		
<b>PLEASE NOTE: The HLD scoring is a guideline for your use and reference. You will still be required to send all required information for prior authorization. Professional Relations 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.</b>		
Examination Completed by: <small>(print name)</small>	Date	
<b>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 may subject me to civil or criminal liability.</b>		
<b>PERFORMING PROVIDER SIGNATURE (INCLUDE CREDENTIALS)</b>	Date	