

Dental Clinical Policy: Orthodontic Treatment

Reference Number:CP.DP.5

Last Review Date: 12/24

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Orthodontics and dentofacial orthopedics is the dental specialty that includes the 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. Acceptability is to be determined by both the patient (or the patient's parent or guardian) and the treating doctor.

Policy/Criteria

- I. It is the policy of Envolve Dental Inc.® that orthodontic treatment is **medically necessary** when the following conditions are met:
 - A. When overjet is equal to or greater than 9.0 mm;
 - B. When reverse overjet is equal to or greater than 3.5 mm;
 - C. When there is anterior and/or posterior crossbite of three (3) or more teeth per arch;
 - D. When there is a lateral or anterior open bite is equal to or greater than 2.0 mm and involving four (4) or more teeth per arch;
 - E. When there is an impinging overbite with evidence of occlusal contact into the opposing soft tissue;
 - F. When there are impactions where eruption is impeded but extraction is not indicated (excluding third molars);
 - G. When jaws and/or dentition are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma, or pathology;
 - H. When there are congenitally missing teeth (excluding third molars) of at least one tooth per quadrant;
 - I. When there is crowding or spacing of 10.0 mm or greater, in either the maxillary or mandibular arch
 - J. When none of the previous conditions apply but the member's condition results in an Envolve Dental verified score of 28 points or greater on the Envolve Dental version of the Handicapping Labial-Lingual Deviation Index form included with this policy document;
 - K. When none of the following contraindications apply:
 1. When there is a crowded dentition (crooked teeth), excessive spacing between, temporomandibular joint (TMJ) conditions, and/or cosmetic purposes;
 2. When an interceptive orthodontic phase of treatment corrects the qualifying conditions for medical necessity;
 3. When the member demonstrates an inability to maintain proper oral hygiene;
 4. When the member has significant restorative dentistry needs;
 - L. Required documentation to support medical necessity include the following:
 1. A current (within six months) diagnostic quality cephalometric image with a calibration gauge on the image;

2. A current (within six months) diagnostic quality panoramic image;
 3. Eight-view full color composite photographic images including diagnostic maxillary and mandibular occlusal views. Claims of overjet and overbite should be verified with a measurement, or photographic image with a measurement;
 4. A definitive diagnosis and comprehensive treatment plan with treatment timeline;
 5. Clinical chart/treatment notes documenting conditions supporting the diagnosis and treatment plan;
 6. A completed Envolve Dental HLD form and any other form (e.g. Salzman, IAF, etc.) required by state-specific regulations.
- II. Categories of Orthodontic Treatment**
- A. Limited orthodontic treatment (D8010, D8020, D8030, D8040) is indicated when:**
1. There is a specific, defined, and limited scope of treatment such as a crossbite or when a tooth needs guidance during eruption;
 2. Appliances such as a rapid palatal expander (RPE) or a retainer may be used to improve a simple problem;
 3. Subject to state-specific regulations for benefit eligibility requirements;
- B. Comprehensive orthodontic treatment (D8070, D8080, D8090) is indicated when:**
1. There is a need to correct medically necessary dentofacial issues including any skeletal, muscular, and/or dental disharmony issues in a transitional, adolescent, or adult dentition;
 2. Treatment may involve dental and medical specialists including, general and pediatric dentists, periodontists, oral surgeons, ENT physicians, psychiatrists, psychologists, and speech pathologists/therapists;
 3. May include the use of the following:
 - a. Rapid palatal expander (RPE);
 - b. Appliances to gain or maintain space;
 - c. Appliances designed to moderate or guide skeletal growth;
 - d. Headgear;
 - e. Herbst appliance;
 - f. Other growth modifiers;
- C. Harmful habits treatment (D8210, D8220) is indicated when:**
1. There is a patient record documenting an oral habit such as thumb sucking or tongue thrusting that cannot be corrected through behavior guidance;
 2. There is evidence of a matching malocclusion to the reported thumb sucking or tongue thrusting habit;
 3. There is documentation from a speech pathologist that a tongue thrust anomaly is present.

Coverage Limitation/Exclusions

- I. Limited to members under the age of 21 (unless state-specific regulations require otherwise);
 - a. In Ohio, an approved orthodontic case is honored to completion of the case regardless of the member's age;
- II. One limited orthodontic case per member per lifetime, subject to state regulations;
- III. 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 phase or category of orthodontic treatment, subject to state regulations.

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 2024, 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.

Comprehensive orthodontic treatment provided within 12 months of limited orthodontic treatment may result in the recoupment of any payment made for limited orthodontic treatment by any of the following means: a) from the payment for the restorative service; b) from the payment for other claimed services; or c) directly from the provider performing the limited orthodontic treatment service(s).

CDT® Codes	Description
D8010	Limited orthodontic treatment for the primary dentition
D8020	Limited orthodontic treatment for the transitional dentition
D8030	Limited orthodontic treatment for the adolescent dentition
D8040	Limited orthodontic treatment for the permanent dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8090	Comprehensive orthodontic treatment of the adult dentition
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8660	Pre-orthodontic treatment examination to monitor growth and development
D8670	Periodic orthodontic treatment visit
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8999	Unspecified orthodontic procedure, by report

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

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
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
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

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 malrelationships 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.

Handicapping Labio-Lingual Deviations (HLD) Index: A method for measuring malocclusion that provides a single score representing the degree to which a case deviates from normal alignment and occlusion.

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.

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.

Salzman Index: A means for establishing priority for treatment of handicapping malocclusion in the individual child according to severity as shown by the magnitude of score obtained in assessing the malocclusion from dental casts or directly in the oral cavity.

Reviews, Revisions, and Approvals	Date	Approval Date
Updated references, procedure and authorization protocol; Added Attachment A – Continuity of Orthodontic Care Form	09/19	09/19
Added ICD-10 indications for orthodontic treatment. Renumbered and restructured clinical policy.	10/20	10/20
Changed policy format, modifications to policy, Added Attachment B – Envolve Dental HLD Index Form	08/21	08/21
Annual Review	12/22	12/22
Annual Review	12/23	12/23
Annual Review	12/24	12/24

References

1. American Dental Association. CDT 2024: Dental Procedure Codes. American Dental Association, 2024.
2. 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/>
3. 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/aaoinfo-leads-effort-establish-consistency-medically-necessary-orthodontic-care>
4. American Association of Orthodontists Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics 2014. Available at: <https://www.aaoinfo.org/system/files/media/documents/2014%20Clinical%20Practice%20Guidelines.pdf>
5. American Association of Orthodontists Guidance on Medically Necessary Orthodontic Care 2019.
6. American Dental Association. CDT 2021 Coding Companion

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. Envolve Dental makes no representations and accepts 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. “Envolve Dental” means a dental plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Benefit Options, Inc, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to dental and 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 Envolve Dental administrative policies and procedures.

This clinical policy is effective as of the date determined by Envolve Dental. 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. Envolve Dental 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 Envolve Dental has no control or right of control. Providers are not agents or employees of Envolve Dental.

This clinical policy is the property of Envolve Dental. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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DENTAL CLINICAL POLICY
Orthodontic Treatment



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Attachment A – Continuity of Orthodontic Care Policy

Purpose

To ensure the proper handling of all orthodontic continuity of care requests.

Policy

The date of band placement for orthodontic treatment is the determination date for responsibility of payment. All members who begin orthodontic treatment when Envolve Dental is the dental benefit administrator are required to seek services with an Envolve Dental contracted provider or orthodontist.

This continuity of care policy applies to members who may have one of the following scenarios surrounding their care:

- A person started as a self-pay patient when orthodontia care started and then became eligible for Medicaid or other health benefit plan and Envolve Dental is the benefit administrator.
- A person was enrolled with one dental benefit administrator when orthodontia services started and changed to Envolve Dental enrollment mid-treatment.
- A person started orthodontic services in another state, relocated, and became eligible for Medicaid or another health benefit plan in the new state, and Envolve Dental is the new dental benefit administrator.
- An Envolve Dental member requests a transfer to a new orthodontist after treatment started.

When Envolve Dental becomes the dental benefit administrator for a member who is in mid-orthodontic treatment, the member can continue services with the original provider for at least the first 90 days of the member's enrollment with Envolve Dental. Envolve Dental will evaluate the treatment plan on a case-by-case basis to determine if the member can remain with the current orthodontic provider after 90 days, or if a transfer should be considered. Envolve Dental will make best efforts to continue treatment at the member's originating orthodontic office until care is completed.

Out-of-Network Providers

If the current provider is not a network participating provider, Envolve Dental may request that the orthodontist enroll in the network, or may consider transferring the member's care to an in-network provider, as long as the member's treatment plan would not be compromised.

Member Relocation

Members who started orthodontic treatment in one state, moved to a different state, and enrolled with Envolve Dental with Medicaid coverage must undergo the current state's evaluation criteria for orthodontic services to determine if the member qualifies for orthodontic treatment in the new state. For other client dental benefit administration contracts, Envolve Dental will follow the client's instructions for transfers from other states. In all cases, Envolve Dental will follow state and federal regulations regarding continuity of care.

Member-Initiated Transfer Request

When a member requests a transfer from his/her orthodontic provider to another because of any other reason than the above, the case will be reviewed and a determination will be made based on all relevant information pertaining to the case.

Procedure

To start a transfer of care request, the member's proposed new orthodontic provider who is to **complete** the orthodontic services should submit a preauthorization request on a 2019 or more recent ADA Claim Form, requesting the service D8999 - unspecified orthodontic procedure. The request should include:

- A copy of the prior health plan's approved authorization;
- A copy of the original provider's ledger showing reimbursement of all services provided to the member, including remits/Explanation of Benefits (EOBs);
- A narrative detailing the remaining treatment plan and request for continuing care. The narrative should include why the case is being submitted for a transfer, and contact information about where the member was treated previously;
- The case fee amount being requested to complete the orthodontic case; and
- A W-9, if the new provider is out-of-network with Envolve Dental.

If the prior dental benefit administrator's approved authorization is not available, then the new orthodontist must also submit the following:

- Panoramic or cephalometric x-ray (dependent on the market – see provider manual)
- Other state-mandated scoring tool (see provider manual); and
- Photos (if available)

This request should be sent to Envolve Dental's state-specific prior authorization address. It shall be processed as an authorization request by the Utilization Management Department, where a Dental Consultant will review the case and issue the provider and member an approval or denial determination upon case review. If the determination is denied, Notifications to the provider and member will include information about how to appeal the decision

**ATTACHMENT B – ENVOLVE DENTAL
HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) SCORE SHEET**

Name (Last, First): _____ Medicaid ID: _____ DOB: _____

All necessary dental work completed? Yes No Patient oral hygiene: Excellent Good Poor

(All dental work must be completed and oral hygiene must be good BEFORE orthodontic treatment is approved)

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

- Indicate by checkmark next to A or B which criteria you are submitting for review
- Position the patient's teeth in centric occlusion;
- Record all measurements in the order given and round off to the nearest millimeter (mm);
- ENTER SCORE "0" IF CONDITION IS ABSENT

A. CONDITIONS 1-9 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present)

- | | |
|---|--------------------------|
| 1. Overjet of 9.0 mm or greater | <input type="checkbox"/> |
| 2. Reverse overjet of 3.5 mm or greater | <input type="checkbox"/> |
| 3. Anterior and/or posterior crossbite of 3 or more teeth per arch | <input type="checkbox"/> |
| 4. Lateral or anterior open bite: 2.0 mm or greater; or, 4 or more teeth per arch | <input type="checkbox"/> |
| 5. Impinging overbite with evidence of occlusal contact into opposing soft tissue | <input type="checkbox"/> |
| 6. Impactions – eruption impeded – extraction not indicated (excluding 3 rd molars) | <input type="checkbox"/> |
| 7. Jaws and/or dentition profoundly affected by congenital or developmental disorder (craniofacial anomalies), trauma, or pathology | <input type="checkbox"/> |
| 8. Congenitally missing teeth (excluding 3 rd molars) of at least 1 tooth per quadrant | <input type="checkbox"/> |
| 9. Crowding or spacing of 10.0 mm or greater – either maxillary or mandibular arch | <input type="checkbox"/> |

Continue to scoring below if there are no qualifying conditions checked above

B. CONDITIONS 10-18 MUST SCORE 28 POINTS OR MORE TO QUALIFY

- | | |
|---|--|
| 10. Overjet (one upper central incisor to labial of the most labial lower incisor) | mm _____ x1= _____ |
| 11. Overbite (maxillary central incisor relative to lower anteriors) | mm _____ x1= _____ |
| 12. Mandibular protrusion (reverse overjet, " underbite ") | mm _____ x5= _____ |
| 13. Openbite (measure from a maxillary central incisor to mandibular incisors) | mm _____ x4= _____ |
| 14. Ectopic teeth (excluding third molars) # teeth | # _____ x3= _____ |
| 15. Anterior crowding of maxilla (greater than 3.5 mm) if present score | Present <input type="checkbox"/> x5= _____ |
| 16. Anterior crowding of mandible (greater than 3.5 mm) if present score | Present <input type="checkbox"/> x5= _____ |
| 17. Labio-lingual spread (either measure a displaced tooth from the normal arch form or labial-lingual distance between adjacent anterior teeth) | mm _____ x1= _____ |
| 18. Posterior crossbite (1 must be a molar), score only 1 time - if present score | Present <input type="checkbox"/> x4= _____ |

TOTAL SCORE (must score 28 points or more to qualify) _____

Provider Signature

Provider Name

Date: _____

NPI #: _____

Phone #: _____

GUIDELINES AND RULES FOR APPLYING THE HLD INDEX

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

1. Indicate by checkmark next to A or B which criteria you are submitting for review.
2. Position the patient's teeth in centric occlusion.
3. Record all measurements in the order given and round off to the nearest millimeter.
4. Enter the score "0" if condition is absent.

A. CONDITIONS 1-9 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present)

B. CONDITIONS 10 - 18 MUST SCORE 28 POINTS OR MORE TO QUALIFY

10. **Overjet** --this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plan. Do *not* use the upper lateral incisors or cuspids. 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 the measurement in millimeters.
11. **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 the measurement in millimeters.
12. **Mandibular (dental) protrusion or reverse overjet** --measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. Do *not* record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by five (5).
13. **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 in millimeters is entered on the score sheet and multiplied by four (4).
14. **Ectopic eruption** --count each tooth excluding third molars. Enter the number of teeth on the score sheet and multiply by three (3).
15. **Anterior crowding of maxilla** --anterior 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. Score one (1) point for a maxillary arch with anterior crowding and one (1) point for a mandibular arch with anterior crowding and multiply by five (5).
16. **Anterior crowding of mandible** -- anterior 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. Score one (1) point for mandibular arch with anterior crowding and multiply by five (5).
17. **Labio-lingual spread** --use a Boley gauge (or disposable ruler) 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 a line representing the normal arch. The total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations should be measured for labiolingual spread but only the most severe individual measurement should be entered on the score sheet. Enter the measurement in mm.
18. **Posterior crossbite** --this condition involves one (1) 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.