Nevada Medicaid and Nevada Check Up

Orthodontic Medical Necessity (OMN) Form

Provider Name: _____ Provider NPI: _____

Recipient Name: _____ Recipient Medicaid ID: _____

Requesting provider must verify the following in order for the patient to qualify for orthodontia:

a. The patient has had all dental work completed: ☐ Yes ☐ No

b. Patient Oral Hygiene: ☐ Good ☐ Fair ☐ Poor

Instructions: *(Assistance from a recorder/hygienist is recommended.)*

1. Enter the requested provider and recipient information above. Provider must sign and date at the bottom.
2. A detailed Treatment Plan is required to be submitted with this form. See pages 2 and 3 for detailed information to be included in the plan.
3. Position the recipient's teeth in centric occlusion.
4. Record all measurements in the order given and round off to the nearest millimeter (mm).
5. Diagnostic photographs demonstrating measurements must be submitted for prior authorization. *Diagnostic photographs means photographs that are clear enough to diagnose from. Photos of mounted models must be accompanied by photos and x-rays of the actual patient.*
6. Measurements must be documented in photos with a Boley gauge, probe, or disposable ruler.
7. For code D8080 comprehensive orthodontics, the recipient must be under 18 years of age and present with a fully erupted set of permanent teeth. At least 1/2 to 3/4 of the clinical crown should be exposed, unless the tooth is impacted or developmentally missing

Requests for orthodontia must explain the significance of one or more of the following considerations of "medical need" (Medicaid Services Manual (MSM) Chapter 1000, Section 1003.8.):

- functional factors relating to conditions that hinder effective functioning;
- factors related to the degree of deformity and malformation which produce a psychological need for the procedure;
- the recipient's overall medical need for the services in light of his/her total medical conditions;
- the medical appropriateness of an orthodontic treatment plan as opposed to other available dental treatment.

Review MSM Chapter 1000 – Dental for complete coverage and limitations policy for Orthodontics.

Medically Necessary Orthodontics are deemed necessary and qualified when it is part of a case involving treatment of cranio-facial anomalies, malocclusions caused by trauma, or a severe malocclusion or cranio-facial disharmony that includes, but is not limited to, the Automatic Qualifying Conditions listed in the table below.

On the following table, indicate the Automatic Qualifying Condition that applies. If more than one condition is indicated, this request will not be reviewed.

Automatic Qualifying Conditions (Medical/Dental Record verification required)	Indicate an X for the condition that applies
a. Overjet equal to or greater than 9 millimeters	
b. Reverse overjet equal to or greater than 3.5 millimeters	
c. Posterior crossbite with no functional occlusal contact	

d.	Lateral or anterior open bite equal to or greater than 4 millimeters	
e.	Impinging overbite with either palatal trauma or mandibular anterior gingival trauma	
f.	One or more impacted teeth where eruption is impeded (excluding third molars)	
g.	Defects of cleft lip or palate or other craniofacial anomalies or trauma	
h.	Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars)	
i.	Anterior crossbite with soft tissue destruction	
j.	Severe Traumatic Deviations (Accident, Trauma, Gross Pathology)	
k.	For EPSDT exception, mark an X and follow directions for Requesting review for medical necessity under EPSDT exception:	

Requesting a Healthy Kids/EPSDT Exception:

Orthodontic treatment must be medically necessary and at a minimum include relief of pain, infection, restoration of teeth, and maintenance of dental health (See MSM Chapter 1500, Section 1503.1A.2). To request a Healthy Kids/EPSDT exception, a detailed Treatment Plan is required. Request for EPSDT Exception must demonstrate a functional impairment indicative of medical necessity. The Treatment Plan must include the following information:

1. Principal diagnosis and significant associated diagnosis
2. Prognosis
3. Date of onset of the illness or condition and etiology, if known
4. Clinical significance or functional impairment caused by the illness or condition
5. Specific services to be rendered by each discipline and anticipated time for achievement of goals
6. Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals
7. Extent of previous services that were provided to address the illness/condition and results of the prior care
8. Any other documentation available which may assist Nevada Medicaid in making the determination

Referring/Prescribing Provider Certification:

I certify under the pains and penalties of perjury that I am the referring provider identified below. Any attached statement has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Referring/Prescribing provider's signature: _____

(Signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

Printed name of referring/prescribing provider: _____

Date: _____

Orthodontic Medical Necessity (OMN) Form

Note: All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters.

Overjet greater than 9 mm: Overjet is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. Canines should not be used to measure overjet. The measurement could apply to a protruding single tooth as well as to the whole arch. Overjet greater than 9 mm must be demonstrated with a measuring device to verify the claimed measurement. The provider must submit a photo with the measuring device (Boley gauge, disposable ruler, or probe) in the patient's mouth, or photo of models demonstrating measurement mounted in centric relation.

Reverse overjet greater than 3.5 mm: Reverse overjet is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. A single tooth in crossbite should not be considered as mandibular

protrusion, but should be evaluated for individual anterior tooth in crossbite with soft tissue destruction. An individual tooth in crossbite with no visible damage to the periodontal tissues is not considered a handicapping malocclusion. For example, Class 1 mobility is not visible damage. Reverse overjet greater than 3.5 mm must be demonstrated with a measuring device to verify the claimed measurement. The provider may submit a photo with the measuring device (Boley gauge, disposable ruler, or probe) in the patient's mouth, or on models mounted in centric relation.

Posterior Unilateral Crossbite with no functional occlusal contact: 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 completely palatal or both completely buccal in relation to mandibular posterior teeth. There must be no functional contact between upper and lower teeth to qualify as a handicapping malocclusion.

Lateral or anterior open bite equal to or greater than 4 millimeters: This condition applies to a general dental or skeletal open bite. A single tooth in ectopic eruption does not qualify as a skeletal or dental open bite. This condition must be demonstrated with a measuring device to verify the claimed measurement. The provider must submit a photo with the measuring device (Boley gauge, disposable ruler, or probe) in the patient's mouth, or on models mounted in centric relation.

Impinging Overbite: Tissue destruction of the palate must be clearly visible in mouth. It must be reproducible and visible. The lower teeth must be clearly touching the palate and there must be clear evidence of damage visible on the submitted documentation; touching or slight indentations do not qualify. **A photo of the mounted casts from the lingual view demonstrating the impingement must be included.** This condition is considered to be a handicapping malocclusion. It is strongly recommended that you submit a clear, well lit, color photo of the maxillary arch that clearly demonstrates the soft tissue damage from the deep impinging overbite.

One or more impacted teeth with eruption that is impeded (excluding third molars): Must be obviously impacted against roots of an adjacent tooth. An unerupted tooth will not be considered impacted. Attach documentation of condition. This condition is considered to be handicapping malocclusion. If it is questionable if the tooth will erupt on its own with sufficient jaw development, the case will be rejected and may be resubmitted in the future if the tooth becomes obviously impacted against roots of an adjacent tooth.

Cleft Palate Deformities: This condition is considered to be a handicapping malocclusion.

Congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars): Patients with at least one congenitally missing tooth per quadrant are considered to have an automatic qualifying condition. Teeth that are missing due to extraction (or other loss) will not be considered under this section.

Individual Anterior Teeth Crossbite with soft tissue destruction: Destruction of soft tissue must be clearly visible in the mouth and reproducible and visible. A minimum of 1.5 mm of tissue recession must be evident to qualify as soft tissue destruction in anterior crossbite cases. This condition is considered to be a handicapping malocclusion. An individual tooth in crossbite with no visible damage to the periodontal tissues is not considered a handicapping malocclusion. For example, Class 1 mobility is not visible damage.

Severe Traumatic Deviations: Traumatic deviations include loss of a premaxilla segment by burns or by accident, the result of osteomyelitis or other gross pathology. Supporting documentation explaining and illustrating the deviation resulting from trauma or damage from gross pathology must be attached for this condition to be considered. This condition is considered to be a handicapping malocclusion.

Cranio-facial Anomaly: REQUIRES CERTIFICATION (Attach report from the "diagnosing specialist" indicating the diagnosis, the severity and scope of diagnosis, and the resulting complications including effect of the diagnosis on occlusion, oral health and oral function.) Examples of cranio-facial anomalies include cleft lip, cleft palate, hemifacial microsomia, deformational plagiocephaly. These would not include normal or skeletal malocclusion.

Surgical Malocclusion with orthognathic surgery: (This does not include extractions for spacing. Examples include B.S.S.O., S.A.R.P.E., and Lefort Osteotomy.) Attach report indicating surgical treatment plan, and orthodontic plan to manage surgical malocclusion.