

Nevada Medicaid and Nevada Check Up  
**Orthodontic Medical Necessity (OMN) Form**

All requested provider/recipient information must be entered. Provider must certify the information entered by signing and dating this form on the bottom of page two. Review [Medicaid Services Manual \(MSM\) Chapter 1000, Section 1003.8 – Orthodontics](#) for complete coverage and limitations policy.

Provider Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Recipient Name: \_\_\_\_\_ Recipient Medicaid ID: \_\_\_\_\_

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

- a. Recipient has had all dental work completed:     Yes                       No
- b. Recipient's Oral Hygiene is:     Good                       Fair                       Poor

**Please note:** For code D8080 comprehensive orthodontics, the recipient must be under 21 years of age and a fully erupted set of permanent teeth must be present. At least 1/2 to 3/4 of the clinical crown should be exposed unless the tooth is impacted or developmentally missing.

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. Nevada Medicaid has adopted the automatic qualifying criteria list developed by the American Association of Orthodontists (AAO). Providers may request orthodontia by 1.) indicating an Automatic Qualifying Condition **or** 2.) requesting an EPSDT/Healthy Kids exception.

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: 9 mm or more	
b. Reverse overjet: 3.5 mm or more	
c. Anterior and/or Posterior crossbite of three or more teeth per arch	
d. Lateral or anterior open bite of 2 mm or more on at least four teeth per arch	
e. Impinging overbite with evidence of occlusal contact into the opposing soft tissue	
f. Impaction where eruption is impeded but extraction is not indicated (excluding third molars)	
g. Jaws and/or dentation which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology	
h. Two or more congenitally missing teeth (extensive hypodontia) of at least one tooth per quadrant (excluding third molars)	
i. Crowding or spacing of 10 mm or more, in either the maxillary or mandibular arch (excluding third molars)	

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<b>EPSDT/Healthy Kids Exception (Medical/Dental Record verification required)</b> 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).	Indicate an X for EPSDT exception
Requesting EPSDT/Healthy Kids Exception	

Requests for orthodontia under an EPSDT exception must demonstrate a functional impairment indicative of medical necessity. The prior authorization (PA) request must explain the significance of one or more of the following considerations of “medical need” (see [MSM Chapter 1000, Section 1003.8 – Orthodontics](#) for complete coverage and limitations policy):

- 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 PA request must include documentation from a Qualified Mental Health Practitioner (QMHP) acting within the scope of their practice that verifies the psychological need.**
- 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.

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

1. Submit diagnostic photographs demonstrating measurements for PA. *Diagnostic photographs means photographs that are clear enough to substantiate and validate the diagnosis. Photos of mounted models must be accompanied by photos and x-rays of the recipient.*
  - a. Position the recipient’s teeth in centric occlusion.
  - b. Record all measurements in the order given and round off to the nearest millimeter (mm).
  - c. Document measurements photos with a Boley gauge, probe or disposable ruler.
2. Submit a detailed treatment plan. See paragraph below for information to be included.
3. Any other documentation available which may assist Nevada Medicaid in making the determination.

**Treatment Plan:**

Providers must include a treatment plan including 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

**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:** \_\_\_\_\_

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### For Automatic Qualifying Conditions

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

- a. **Overjet 9 mm or more:** Overjet is recorded with the recipient 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 of 9 mm or more 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 recipient's mouth, or photo of models demonstrating measurement mounted in centric relation.
- b. **Reverse overjet 3.5 mm or more:** Reverse overjet is recorded with the recipient 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 of 3.5 mm or greater must be demonstrated with a measuring device to verify the claimed measurement. The provider should submit a photo with the measuring device (Boley gauge, disposable ruler or probe) in the recipient's mouth, or on models mounted in centric relation.
- c. **Anterior and/or posterior crossbite of three or more teeth per arch:** The posterior 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. The posterior crossbite involves two or more adjacent teeth, and one tooth must be a molar. The anterior crossbite must be one in which three or more of the anterior maxillary teeth are lingual to the anterior mandibular teeth. There must be no functional contact between upper and lower teeth to qualify as a handicapping malocclusion.
- d. **Lateral or anterior open bite of 2 mm or more on at least four teeth per arch:** 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 recipient's mouth, or on models mounted in centric relation. For anterior teeth, the measurement should be placed from incisal edge to incisal edge, and for posterior teeth, the measurement should be from cusp tip to cusp tip to demonstrate the edge-to-edge relationship.
- e. **Impinging Overbite with evidence of occlusal contact into the opposing soft tissue:** Tooth contact with the palate or gingiva must be clearly evident in mouth. It must be reproducible and visible. On the submitted documentation, the lower teeth must be clearly touching the palate and there must be clear evidence of significant contact and indentation. A photo of the electronic models/scan or 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 providers submit a clear, well lit, color photo of the maxillary arch that clearly demonstrates the deep impinging overbite and the resulting soft tissue condition.
- f. **Impaction where eruption is impeded but extraction is not indicated (excluding third molars):** Must be obviously impacted against roots of an adjacent tooth. An unerupted tooth will not be considered impacted. Providers must 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.
- g. **Jaws and/or dentition which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology:** This condition is considered to be a handicapping malocclusion. For craniofacial anomalies, providers must 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. This section also includes malocclusion due to trauma. For trauma or pathology, a detailed medical history report should be submitted.
- h. **Two or more congenitally missing teeth (excluding third molars) of at least one tooth per quadrant:** The recipient should have two or more congenitally missing teeth. All of the congenitally missing teeth cannot be in the same quadrant. This means at least two quadrants must be affected by the missing teeth. Teeth that are missing due to extraction (or other loss) will not be considered under this section.
- i. **Crowding or spacing of 10 mm or more, in either the maxillary or mandibular arch (excluding third molars):** The provider must submit a photo with the measuring device (Boley gauge, disposable ruler or probe) in the recipient's mouth, or on models mounted in centric relation.

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### For EPSDT/Healthy Kids Exceptions

**Through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** benefits, individuals under the age of 21 receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention of oral disease and maintenance of dental health. The EPSDT program assures children receive the full range of necessary dental services, including orthodontia when medically necessary and pre-approved by the Nevada Medicaid Quality Improvement Organization (QIO)-like vendor. The EPSDT screening provider may refer children for dental services.

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

**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.

**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.