

Commonwealth of Massachusetts MassHealth Provider Manual Series Dental Manual	Subchapter Number and Title Appendix D: Authorization Form for Comprehensive Orthodontic Treatment	Page D-1
	Transmittal Letter DEN-96	Date 07/01/16

AUTHORIZATION FORM FOR COMPREHENSIVE ORTHODONTIC TREATMENT

MassHealth Handicapping Labio-Lingual Deviations Index

FOR OFFICE USE ONLY First Reviewer _____ Second Reviewer _____ Third Reviewer _____

The Handicapping Labio-Lingual Deviations Index (HLD) is a quantitative, objective method for evaluating prior authorization requests for comprehensive orthodontic treatment. The HLD allows for the identification of certain autoqualifying conditions and provides a single score, based on a series of measurements, which represent the presence, absence, and degree of handicap. The HLD **must** be submitted with all prior-authorization requests for comprehensive orthodontic treatment.

The following documents **must** also be submitted with this form. X-rays photos

Procedure

1. Occlude patient or models in centric occlusion.
2. Record all measurements in the order given and rounded off to the nearest millimeter.
3. **Enter score "0" if condition is absent.**
4. Start by measuring **overjet** of the most protruding incisor.
5. Measure **overbite** from the labio-incisal edge of overlapped front tooth (or teeth) to point of maximum coverage.
6. Score all other conditions listed.
7. **Ectopic eruption** and **anterior crowding**: **Do not double score.** Record the more serious condition.
8. Deciduous teeth and teeth not fully erupted should not be scored.

Patient's Name (please print) _____ Member ID _____

Address _____

Street
City/County
State
Zip Code

AUTOQUALIFIERS	Condition Observed	
Cleft Palate or Cranio-Facial Anomaly	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Deep Impinging Overbite *with severe soft tissue damage (e.g., ulcerations or tissue tears – more than indentations)*	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anterior Impactions where extraction is not indicated	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Severe Traumatic Deviations – This refers to facial accidents rather than congenital deformity. Do not include traumatic occlusions or crossbites.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Overjet (greater than 9mm)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Reverse Overjet (greater than 3.5mm)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Severe Maxillary Anterior Crowding (greater than 8mm)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HLD SCORING	Measurement	Score
Overjet (in mm)	# mm X 1	
Overbite (in mm)	# mm X 1	
Mandibular Protrusion (in mm) – See scoring instructions.	# mm X 5	
Anterior Open Bite – Do not count ectopic eruptions, measure the opening between maxillary and mandibular incisors in mm.	# mm X 4	
Ectopic Eruption (number of teeth, excluding third molars) – This refers to an unusual pattern of eruption such as high labial cuspids. Do not score teeth in this category if they are scored under maxillary or mandibular crowding.	# of teeth X 3	
Anterior Crowding – If crowding exceeds 3.5mm in an arch, score each arch.	Maxilla: 5 points Mandible: 5 points	

Commonwealth of Massachusetts MassHealth Provider Manual Series Dental Manual	Subchapter Number and Title Appendix D: Authorization Form for Comprehensive Orthodontic Treatment	Page D-2
	Transmittal Letter DEN-96	Date 07/01/16

	Both: 10 points	
Labio-Lingual Spread (anterior spacing in mm) – See scoring instructions.	# mm X 1	
Posterior Unilateral Crossbite – Must involve 2 or more teeth, one of which must be a molar	4 points	
Posterior impactions or congenitally missing posterior teeth (excluding 3 rd molars)	# teeth X 3	
TOTAL		
Treatment will be authorized for cases with verified autoqualifiers or verified scores of 22 and above.		

Medical Necessity Narrative

MEDICAL NECESSITY NARRATIVE	
Are you submitting a Medical Necessity Narrative?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, are you submitting additional supporting documentation?	Yes <input type="checkbox"/> No <input type="checkbox"/> The medical necessity determination does not involve any mental, emotional, behavioral or other condition outside the professional expertise of the requesting provider and, therefore, the submitted narrative does not incorporate or rely on the opinion or expertise of anyone other than the requesting provider.
<p>Instructions for Medical Necessity Narrative and Supporting Documentation (if applicable)</p> <p>Providers may establish that comprehensive orthodontic treatment is medically necessary by submitting a medical necessity narrative and supporting documentation, where applicable. The narrative must establish that comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion, including to correct or significantly ameliorate</p> <ol style="list-style-type: none"> i. a severe deviation affecting the patient’s mouth and/or underlying dentofacial structures; ii. a diagnosed mental, emotional, or behavioral condition caused by the patient’s malocclusion; iii. a diagnosed nutritional deficiency and/or a substantiated inability to eat or chew caused by the patient’s malocclusion; iv. a diagnosed speech or language pathology caused by the patient’s malocclusion; or v. a condition in which the overall severity or impact of the patient’s malocclusion is not otherwise apparent. <p>Providers may submit a medical necessity narrative (along with the required completed HLD) in any case where, in the professional judgment of the requesting provider and any other involved clinician(s), comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion. Providers must submit this narrative in cases where the patient does not have an autoqualifying condition or meet the threshold score on the HLD, but where, in the professional judgment of the requesting provider and any other involved clinician(s), comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion.</p> <p>The medical necessity narrative must clearly demonstrate why comprehensive orthodontic treatment is medically necessary for the patient. If any part of the requesting provider’s justification of medical necessity involves a mental, emotional, or behavioral condition; a nutritional deficiency; a speech or language pathology; or the presence of any other condition that would typically require the diagnosis, opinion, or expertise of a licensed clinician other than the requesting provider, then the narrative and any attached documentation must</p>	

Commonwealth of Massachusetts MassHealth Provider Manual Series Dental Manual	Subchapter Number and Title Appendix D: Authorization Form for Comprehensive Orthodontic Treatment	Page D-3
	Transmittal Letter DEN-96	Date 07/01/16

- i. clearly identify the appropriately qualified and licensed clinician(s) who furnished the diagnosis or opinion substantiating the condition or pathology (e.g., general dentist, oral surgeon, physician, clinical psychologist, clinical dietitian, speech therapist);
 - ii. describe the nature and extent of the identified clinician(s) involvement and interaction with the patient, including dates of treatment;
 - iii. state the specific diagnosis or other opinion of the patient's condition furnished by the identified clinician(s);
 - iv. document the recommendation by the clinician(s) to seek orthodontic evaluation or treatment (if such a recommendation was made);
 - v. discuss any treatments for the patient's condition (other than comprehensive orthodontic treatment) considered or attempted by the clinician(s); and
 - vi. provide any other relevant information from the clinician(s) that supports the requesting provider's justification of the medical necessity of comprehensive orthodontic treatment.
- The medical necessity narrative must be signed and dated by the requesting provider and submitted on the office letterhead of the provider. If applicable, any supporting documentation from the other involved clinician(s) must also be signed and dated by such clinician(s), and appear on office letterhead of such clinician(s). The requesting provider is responsible for coordinating with the other involved clinician(s) and is responsible for compiling and submitting any supporting documentation furnished by other involved clinician(s) along with the medical necessity narrative.

Attestation

I certify under the pains and penalties of perjury that I am the prescribing provider identified on this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) 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.

Prescribing provider's signature:

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

Printed name of prescribing provider _____ Date _____

Commonwealth of Massachusetts MassHealth Provider Manual Series Dental Manual	Subchapter Number and Title Appendix D: Authorization Form for Comprehensive Orthodontic Treatment	Page D-4
	Transmittal Letter DEN-96	Date 07/01/16

Handicapping Labio-Lingual Deviation Index Scoring Instructions

All measurements are made with a measurement tool scaled in millimeters. Absence of any conditions must be recorded by entering "0."

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

1. **Cleft Palate Deformities:** Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
2. **Deep Impinging Overbite:** Indicate an "X" on the form when lower incisors are destroying the soft tissue of the palate (e.g., ulcerations or tissue tears—more than indentations). *(This is considered an autoqualifying condition.)*
3. **Anterior Impactions:** Indicate an "X" on the form. Anterior impactions include central incisors, lateral incisors, and canines in the maxillary and mandibular arches. *(This is considered an autoqualifying condition.)*
4. **Severe Traumatic Deviations:** Indicate an "X" on the form. Traumatic deviations refer to facial accidents rather than congenital deformity. For example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Do not include traumatic occlusions or crossbites. *(This is considered an autoqualifying condition.)*
5. **Overjet Greater Than 9mm:** Indicate an "X" on the form. This 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. The measurement could 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 form. *(This is considered an autoqualifying condition.)*
6. **Reverse Overjet Greater Than 3.5mm:** Indicate an "X" on the form. This 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. *(This is considered an autoqualifying condition.)*
7. **Severe Maxillary Anterior Crowding, Greater Than 8mm:** Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
8. **Overjet in Millimeters:** This 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. The measurement could 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 form.
9. **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 form. "Reverse" overbite may exist in certain conditions and should be measured and recorded.
10. **Mandibular Protrusion in Millimeters:** Score exactly as measured from the buccal groove of the first mandibular molar to the MB cusp of the first maxillary molar. The measurement in millimeters is entered on the form and multiplied by 5.
11. **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. This measurement is entered on the form and multiplied by 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.
12. **Ectopic Eruption:** Count each tooth, excluding third molars. Enter the number of teeth on the form and multiply by 3. If condition no. 13, 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.
13. **Anterior Crowding:** Arch length insufficiency must exceed 3.5 mm. Do not score mild rotations that may react favorably to stripping or mild expansion procedures. Enter 5 points for maxillary and mandibular anterior crowding. If condition no. 12, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. Do not score both conditions.
14. **Labio-Lingual Spread:** The measurement tool 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 that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth

Commonwealth of Massachusetts MassHealth Provider Manual Series Dental Manual	Subchapter Number and Title Appendix D: Authorization Form for Comprehensive Orthodontic Treatment	Page D-5
	Transmittal Letter DEN-96	Date 07/01/16

and the 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 labio-lingual spread, but only the most severe individual measurement should be entered on the index.

Additionally, anterior spacing may be measured as the total score in mm from the mesial of cuspid to the mesial of cuspid, totaling both arches.

Enter only the highest score attained by any of the above methods.

15. 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 the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of 4 on the form.

16. Posterior Impactions or Congenitally Missing Posterior Teeth: Total the number of posterior teeth, excluding third molars that meet this criterion and multiply by 3.

<p align="center">Commonwealth of Massachusetts MassHealth Provider Manual Series</p>	<p align="center">Subchapter Number and Title Appendix D: Authorization Form for Comprehensive Orthodontic Treatment</p>	<p align="center">Page D-6</p>
<p align="center">Dental Manual</p>	<p align="center">Transmittal Letter DEN-96</p>	<p align="center">Date 07/01/16</p>

This page is reserved.