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Questionnaire: Orthodontia Medical Necessity

MEDICAL NECESSITY QUESTIONNAIRE FOR DHS ORTHODONTIA CRITERIA

1. *Is there an overjet of 9 mm or greater?*
   (Please select one.)
   - ○ Yes
   - ○ No

   If you answered "Yes" on question 1

   1.1.1. *Select the exact measurement in millimeters: NOTE: measurements in mm must be submitted in Clinical documentation.*
   (Please select one.)
   - ○ 9 mm
   - ○ 10 mm or greater

2. *Is the Reverse overjet 3.5 mm or greater?*
   (Please select one.)
   - ○ Yes
   - ○ No

   If you answered "Yes" on question 2

   2.1.1. *Please enter the exact measurements in millimeters:*

3. *Is there an Anterior and/or Posterior crossbite involving 3 or more teeth per arch?*
   (Please select between 1 and 2 items.)
   - ☐ Anterior
   - ☐ Posterior
   - ☐ None

   If you answered "Anterior" on question 3

3.2.1. *Anterior tooth number(s)*
(Please select between 1 and 12 items.)

- ☐ 6 ☐ 7
- ☐ 8 ☐ 9
- ☐ 10 ☐ 11
- ☐ 22 ☐ 23
- ☐ 24 ☐ 25
- ☐ 26 ☐ 27

If you answered "Posterior" on question 3

3.3.1. *Posterior tooth number(s)*
(Please select between 1 and 8 items.)

- ☐ 2 ☐ 3
- ☐ 4 ☐ 5
- ☐ 12 ☐ 13
- ☐ 14 ☐ 15
- ☐ 18 ☐ 19
- ☐ 20 ☐ 21
- ☐ 28 ☐ 29
- ☐ 30 ☐ 31

4. *Is there a Posterior and/or Anterior open bite 2 mm or more involving 4 or more teeth per arch? NOTE: measurements in mm must be submitted in Clinical documentation.*
(Please select between 1 and 2 items.)

- ☐ Posterior
- ☐ Anterior
- ☐ None

If you answered "Posterior" on question 4

4.2.1. *Posterior tooth number(s)*
(Please select between 1 and 8 items.)

- ☐ 2 ☐ 3
- ☐ 4 ☐ 5
- ☐ 12 ☐ 13
- ☐ 14 ☐ 15
- ☐ 18 ☐ 19
- ☐ 20 ☐ 21
- ☐ 28 ☐ 29
- ☐ 30 ☐ 31

☐ 20 ☐ 21
☐ 28 ☐ 29
☐ 30 ☐ 31

If you answered "Anterior" on question 4

4.3.1. *Anterior tooth number(s)*
(Please select between 1 and 12 items.)

☐ 6 ☐ 7
☐ 8 ☐ 9
☐ 10 ☐ 11
☐ 22 ☐ 23
☐ 24 ☐ 25
☐ 26 ☐ 27

5. *Is there an impinging overbite with evidence of occlusal contact of opposing soft tissue?*
(Please select one.)

○ Yes
○ No

If you answered "Yes" on question 5

5.1.1. *Anterior tooth number(s)*
(Please select between 1 and 12 items.)

☐ 6 ☐ 7
☐ 8 ☐ 9
☐ 10 ☐ 11
☐ 22 ☐ 23
☐ 24 ☐ 25
☐ 26 ☐ 27

6. *Is there an Impaction where eruption is impeded but extraction is not indicated (excluding 3rd molars)?*
(Please select one.)

○ Yes
○ No

If you answered "Yes" on question 6

6.1.1. *Anterior tooth number(s)*
(Please select between 1 and 12 items.)

☐ 6 ☐ 7
☐ 8 ☐ 9
☐ 10 ☐ 11
☐ 22 ☐ 23
☐ 24 ☐ 25
☐ 26 ☐ 27

- ☐ 22 ☐ 23
- ☐ 24 ☐ 25
- ☐ 26 ☐ 27

6.1.2. *Posterior tooth number(s)*
(Please select between 1 and 8 items.)

- ☐ 2 ☐ 3
- ☐ 4 ☐ 5
- ☐ 12 ☐ 13
- ☐ 14 ☐ 15
- ☐ 18 ☐ 19
- ☐ 20 ☐ 21
- ☐ 28 ☐ 29
- ☐ 30 ☐ 31

7. *Is the Jaw and/or dentition profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 7

7.1.1. *Please list the condition(s):*

8. *Are there Congenitally missing teeth (excluding 3rd molars) of at least 1 tooth per quadrant?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 8

8.1.1. *Quadrant 10 tooth numbers:*
(Please select between 1 and 7 items.)

- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6

- ☐ 7
- ☐ 8

8.1.2. *Quadrant 20 tooth numbers:*
(Please select between 1 and 7 items.)

- ☐ 9
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15

8.1.3. *Quadrant 30 tooth numbers:*
(Please select between 1 and 7 items.)

- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24

8.1.4. *Quadrant 40 tooth numbers:*
(Please select between 1 and 7 items.)

- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28
- ☐ 29
- ☐ 30
- ☐ 31

9. *Is crowding or spacing of 10 mm or greater in either maxillary or mandibular arch (excluding 3rd molars)? NOTE: measurements in mm must be submitted in Clinical documentation.*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 9

If you answered "Yes" on question 9

9.1.1. *Maxillary with 10mm or greater*
(Please select between 1 and 2 items.)
- ☐ Crowding
- ☐ Spacing

9.1.2. *Mandibular*
(Please select between 1 and 2 items.)
- ☐ Crowding
- ☐ Spacing

Attestation

1. *Has the specific treatment plan and appliances (enter the appropriate procedure code) been uploaded?*
(Please select one.)
   - ○ Yes
   - ○ No

2. *Are five intraoral photographs including upper and lower occlusal, profile photos uploaded?*
(Please select one.)
   - ○ Yes
   - ○ No

3. *Are the appropriate radiographs (panoramic or full mouth and cephalometric) uploaded?*
(Please select one.)
   - ○ Yes
   - ○ No

4. *Has the active, banded treatment time expected (listed in months) been uploaded?*
(Please select one.)
   - ○ Yes
   - ○ No

5. *Have measurements in mm been uploaded with the Clinical documentation for crowding/cross bites/overbite/overjet/ open bite?*
(Please select one.)
   - ○ Yes
   - ○ No

6. *By checking "I agree" and typing my name in the "Electronic Signature" field, I understand that I am electronically signing this form. In addition, I attest and certify that I have verified the profile change against an acceptable form of identification and that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. 325L.07) *** You MUST attach documentation to support the answers given in the questionnaire ****

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(Please select one.)

- ○ I agree

7. *Electronic Signature*

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