First Review ____

Second Review ____

Models ____

Orthocad ____
Ceph Films ____

X-Rays ____
Photos ____
Narrative ___

HEALTH FIRST COLORADO ORTHODONTIC CRITERIA INDEX FORM COMPREHENSIVE ORTHODONTIC TREATMENT (D8070, D8080, D8090

8.280.5.F. Orthodontic services are available for children with congenital, severe developmental or acquired handicapping malocclusions when the orthodontist documents Medical Necessity that is confirmed by pre-treatment case review. Orthodontists shall submit requests for prior authorization of covered orthodontic services." 10 Colo. Code Regs. § 2505-10-8.280.5

Patient Name: _____ DOB: _____ Medicaid Number: _____

Abbreviations	CRITERIA	YES	NO
DO	Deep impinging overbite with the palatal impingement of 1 (one) or more lower incisors. Photos or models must be shown at an angle to clearly demonstrate palatal impingement.		
AO	Skeletal anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted)		
AP	Demonstrates a large anterior-posterior discrepancy. (Class II and Class III malocclusions that are) greater than a full-cusp (step) Class II or III, either side)		
AX	Anterior maxillary crossbite. (Involves three or more anterior teeth in full crossbite or in cases where gingival recession of 1.5mm or greater resulting from the crossbite is demonstrated).Partial crossbites or teeth occluding edge-to-edge do not qualify.		
PX	Posterior transverse discrepancies (involves 3 or more posterior teeth in crossbite in the arch, one of which must be a molar).Photos or models must clearly demonstrate maxillary buccal cusps positioned lingual to mandibular buccal cusps or maxillary lingual cusps positioned buccal to mandibular buccal cusps.		
PO	Significant posterior openbites. (Not involving unerupted teeth or one or two teeth slightly out of occlusion. Openbite must be amenable to orthodontic correction. i.e. not Primary Failure of Eruption)		
IMP	Impacted incisors or canines that will not erupt into the arches without orthodontic and/or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically).		
CR	Crowding of greater than 7mm in either the maxillary or mandibular arch. Photos or models must clearly demonstrate a tooth size-arch length discrepancy of greater than 7mm.		
OJ	Overjet in excess of 9mm. (measure from lingual of the maxillary incisor tip to the labial of the mandibular incisor tip). Measure most affected tooth. Photos or cephalogram must clearly demonstrate the presence of this condition.		
CDD	Congenital, developmental or traumatic deformity with a significant accompanying dental deformity. (Provide evidence and narrative of deformity below).		
FAS	Severe skeletal malocclusion requiring orthodontics and orthognathic surgery. (Medical prior approval required).		

Additional information demonstrating severe handicapping malocclusion: Note: Only one of the listed criteria is necessary for qualification/approval of the treatment plan

_____

_____

. APPROVED: _____ DENIED: _____ **Reviewed by:** _____

Date:_____

First Review ____

Second Review ____

Models ____

Orthocad ____
Ceph Films ____

X-Rays ____
Photos ____
Narrative ___

DentaQuest

COLORADO ORTHODONTIC CRITERIA INDEX FORM B – ORTHODONTIC TREATMENT (D8010, D8020)

Patient Name: _____ DOB: _____ Medicaid Number: _____

CRITERIA	YES	NO
Two or more teeth 6-11 in crossbite with photograph documenting 100% of the incisal edge in complete overlap with opposing tooth/teeth.		
Bilateral crossbite of teeth 3/30 and 14/19 with photographs documenting cusp overlap completely in fossa, or completely buccal / lingual of opposing teeth.		
Bilateral crossbite of teeth A/T and J/K with photographs documenting cusp overlap completely in fossa, or completely buccal or lingual of opposing tooth.		
Crowding with radiograph documenting current bony impaction of a tooth 6-11, 22-27 that requires either serial extractions or surgical exposure and guidance for the impacted tooth to erupt into the arch.		
Crowding with radiograph documenting resorption of 25% of the root of an adjacent permanent tooth.		
Unilateral crossbite with a functional shift.		

Additional factors for consideration:

_____

Note: Only one of the listed criteria is necessary for qualification/approval of the treatment plan.

APPROVED: ❒ **DENIED:** ❒

Reviewed by: _____ Date: _____