471-000-406 Nebraska Medicaid Handicapping Labiolingual Deviation (HLD) Index - (NE-Mod) Orthodontic Diagnostic Score Sheet:

Handicapping Labiolingual Deviation (HLD) Index - NE (Mod):

The submitting dentist shall complete and submit the Handicapping Labiolingual Deviation (HLD) Index score sheet when submitting an orthodontic pre-treatment request. The attached score sheet may be photo copied by the dental office for completion and submission.

If the diagnosed condition does not qualify in 1 through 6 listed on the Handicapping Labiolingual Deviation (HLD) Index the dental provider must complete items 7 through 14. The total score on 7 through 14 of the Handicapping Labiolingual Deviation (HLD)Index must be 28 or greater to qualify for Medicaid coverage of orthodontic treatment.

REV. DECEMBER 13, 2023 NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID SERVICES 471-000-406

NEBRASKA MEDICAID HANDICAPPING LABIO-LINGUAL DEVIATIONS FORM (HLD INDEX)

THIS FORM IS A QUANTITATIVE, OBJECTIVE METHOD FOR MEASURING MALOCCLUSION. THE HLD PROVIDES A SINGLE SCORE, BASED ON A SERIES OF MEASUREMENTS THAT REPRESENT THE DEGREE TO WHICH A CASE DEVIATES FROM NORMAL ALIGNMENT AND OCCLUSION.

PATIENT INFO

CLIENT NAME: _____CLIENT MEDICAID NUMBER_____

CLIENT ADDRESS:_____CLIENT DATE OF BIRTH ___/____/_____

PROVIDER INFO (must be 20 years old or under)

PROVIDER NAME:_____PROVIDER ID NUMBER:_____

CONDITIONS OBSERVED

PROCEDURE: SCORING STEPS 1 THROUGH 6. IF ONE OF THESE CONDITIONS EXIST, INDICATE WITH AN "X" AND SCORE NO FURTHER.

1. DEEP IMPINGING OVERBITE. SCORE "X"_____
2. CROSSBITE OF THREE OR MORE PERMANENT AND/OR DECIDUOUS POSTERIOR TEETH OR ANTERIOR CROSSBITE OF ONE TO TWO TEETH. SCORE "X"_____
3. CONGENITAL BIRTH DEFECT THAT AFFECTS SKELETAL RELATIONSHIP AND/OR DENTITION. SCORE "X"_____
4. IMPACTED CUSPIDS WITH MOST OF THE PERMANENT DENTITION PRESENT. SCORE "X"_____
5. OVERJET GREATER THAN 9 MM OR ANTERIOR CROSSBITE. SCORE "X"_____
6. MALOCCLUSION WITH OPEN BITE FROM CANINE TO CANINE. SCORE "X"_____

IF YOU HAVE MARKED AN "X" IN ANY OF THE ABOVE; **STOP**; AND PROCEED TO PRIOR AUTHORIZATION STEP 16.

PROCEDURE: COMPLETE 7 through 14 IF CASE DOES NOT QUALIFY IN 1 through 6 ABOVE. THE TOTAL SCORE WILL DETERMINE IF THE CASE QUALIFIES FOR ORTHODONTIC TREATMENT. COMPLETE INSTRUCTIONS ARE ON THE SECOND PAGE; "SCORING INSTRUCTIONS FOR HANIDAPPING MALOCCLUSION."

- POSITION THE PATIENT'S TEETH IN CENTRIC OCCLUSION. RECORD MEASUREMENTS N THE ORDER GIVEN AND ROUND TO THE NEAREST MILLIMETER (MM).
- ENTER SCORE "0" IF CONDITION IS ABSENT.
- NOTE: WHEN COMPLETEING 11 AND 12, IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE MOUTH, SCORE ONLY THE MOST SEVER CONDITION. DO NOT SCORE BOTH CONDITIONS.

7. OVERJET IN MM. (1 - 8 MM) _____
8. OVERBITE IN MM. (ANTERIOR CROSSBITE) _____
9. MANDIBULAR IN PROTRUSION, IN MM. X5_____
10. OPEN BITE, IN MM. X4 _____
11. ECTOPIC ERUPTION: COUNT EACH TOOTH EXCLUDING 3RD MOLARS.
    LIST TEETH_____ # OF TEETH X3_____
12. ANTERIOR CROWDING OR SPACING: SCORE ONE POINT FOR MAXILLA, AND/OR ONE POINT FOR MANDIBLE; TWO POINT MAXIMUM. SCORE THE ONE OR TWO X5. # X5 _____
13. LABIOLINGUAL SPREAD IN MM. _____
14. POSTERIOR UNILATERAL CROSSBITE. (MUST INVOLVE TWO OR MORE ADJACENT TEETH, ONE OF WHICH MUST BE A MOLAR)
    IF PRESENT SCORE 4 _____

A TOTAL SCORE OF 28 OR GREATER CONSTITUTES A HANDICAPPING MALOCCLUSION: TOTAL OF 7 through 14 _____

IF 7 – 14 ABOVE SCORED 28 OR GREATER, PROCEED TO PRIOR AUTHORIZATION STEP 16.

15. IF TOTAL SCORE IS 27 OR UNDER**, STOP**, DO NOT PROCEED TO PRIOR AUTHORIZTION STEP 16. A SCORE OF 27 OR UNDER WILL NOT BE REVIEWED, CONSIDER THIS SCORE SHEET AS PROOF OF DENIAL FOR CONSIDERATION. DO NOT PROCEED TO COMPLETE AND BILL FOR CEPH FILM AND DIAGNOSTIC CASTS, THEY MAY NOT BE PAID WITHOUT AN ORTHODONTIC TREATMENT APPROVAL.
16. IF THE ABOVE CONDITIONS QUALIFY FOR A REVIEW (YOU MUST HAVE AN "X" AND/OR A SCORE OF 28 OR ABOVE) YOU MAY PROCEED TO SUBMIT FOR PRIOR AUTHORIZATION WITH REQUIRED DOCUMENTATION CHECKED OFF BELOW. IN ORDER FOR MEDICAID PATIENTS TO RECEIVE TIMELY TREATMENT, PLEASE CONSIDER YOUR REQUEST FOR APPROVAL AS YOUR ACCEPTANCE OF THE MEDICAID FEE AND A COMMITMENT TO COMPLETE CARE. ADA FORM ____ CEPH FILM ____ X-RAYS _____ PHOTOS _____ NARRATIVE _____

Handicapping Labiolingual Index (HLD) - (NE-Mod)
Scoring Instructions for Severe Malocclusions

The intent of the HLD Index is to measure the presence or absence, and the degree, of the handicap caused by the components of the index, and not to diagnose "malocclusion." All measurements are made with a Boley Gauge (or disposable ruler) scaled in millimeters. Absence of any condition must be recorded by entering "0" on 7 - 14. Measurements are rounded to the nearest millimeter.

1 – 6. Indicate an "X" on the score-sheet. These conditions are automatically considered a handicapping malocclusion and no further scoring is necessary.

7. Overjet in Millimeters: This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. Enter the number of millimeters as the HLD score.

8. Overbite in Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. Anterior crossbite may exist in certain conditions and should be measured and recorded. Enter the number of millimeters as the HLD score. (Vertical measurement.)

9. Mandibular Protrusion in Millimeters: Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. A anterior crossbite, if present, should be shown under "overbite". The measurement in millimeters is entered on the score-sheet and multiplied by five (5). Enter the multiplied total as the HLD score. (Horizontal measurement.)

10. 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. In cases of pronounced protrusion associated with open bite, measurement of the open bite should be estimated. The measurement is entered on the score-sheet and multiplied by four (4). Enter the multiplied total as the HLD score.

11. Ectopic Eruption: Count each tooth. Teeth deemed to be ectopic must be more than 50% blocked out and clearly out of the dental arch. Mutually blocked teeth are counted one time and third molars are excluded. If condition #12, 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. Enter the number of teeth on the score-sheet and multiply by three (3). Enter the multiplied total as the HLD score.

12. Anterior Crowding or spacing: Arch length insufficiency or excess must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. If condition #11, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. DO NOT SCORE BOTH CONDITIONS. Two point maximum multiplied by five (5) for a maximum score of 10. Enter the multiplied total as the HLD score.

13. Labiolingual Spread: A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labiolingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. If multiple anterior crowding of teeth is present only the most severe individual millimeter measurement should be entered on the index. Enter the number of millimeters as the HLD score.

14. 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 be both palatal or both completely buccal in relation to the mandibular posterior teeth. If posterior unilateral crossbite is present enter four (4) as the HLD score.

Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request Form

Patient Name: **Patient's Medicaid #:**

Birthdate: **Date of Request:**

Provider Name: **Provider Medicaid #:**

Provider Address: (Street, City, State, Zip) **Phone Number:**

Treatment Request:	Maxillary Arch	Mandibular Arch	Fee	Administrative Use Only
Inclined plane (Hawley) appliance, bite plane, with clasps				
Cross-bite appliance, anterior, acrylic				
Cross-bite appliance, posterior, two bands plus attachments				
Adjustments of appliance (# each arch)				
Space maintainer – fixed – unilateral				
Space maintainer – fixed – bilateral				
Description appliance not listed:				

	Number Requested	Fee	Administrative Use Only
Chrome steel wire clasps – each .036 or minimum .030			
Attachment springs for appliance, each			

Diagnostic Narrative:

Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request Form

Patient Name: Enter the full name (first, middle initial, and last name) of the client.

Patient's Medicaid #: Enter the client's eleven-digit Medicaid identification number.

Birthdate: Enter the client's month, day and year of birth.

Date of Request: Enter the submission date for the request.

Provider Name: Enter the dentist name.

Provider Medicaid #: Enter the eleven-digit Medicaid provider number.

Provider Address: Enter the dentist office address (Street, City, State, and Zip).

Provider Phone Number: Enter the dentist office phone number.

Treatment Request:

- Appliances: Under the Maxillary Arch and Mandibular Arch column check the type of appliances being requested.
- Adjustments of pedodontic and interceptive appliances: Enter the number of adjustments for the Maxillary arch and Mandibular Arch in the appropriate column.
- Chrome steel wire clasps - enter the number of clasps requested.
- Attachment springs for appliance - enter the number of springs requested.
- Enter the dentist usual and customary fee for each treatment being requested.

Diagnostic Narrative: Provide information regarding the diagnosis and treatment requested.

Nebraska Medicaid Comprehensive Orthodontic Pre-Treatment Request Form

Patients Name: Patient's Medicaid #:

Birthdate: Date of Request: Surgical Correction: Yes No Surgical Diagnosis:

Provider Name: Provider Medicaid #:

Provider Address: (Street, City, State, Zip) Phone Number:

Treatment Request	**Maxillary Arch**	**Mandibular Arch**	**Fee**	**Administrative Use Only**
Construct & place fixed appliance, active trt.				
Number of monthly adjustments per arch				
Retainer or retention appliance				
Number of monthly retention visits, per arch				
Other Appliances:				
Rapid palatal expander (RPE)				
Crossbite correcting (fixed appliance)				
Herbst appliance				
Protraction facemask				
Slow expansion appliance				
Headgear				
Space maintainer – fixed - unilateral				
Space Maintainer – fixed – bilateral				
Description orthodontic appliance not listed:				

Diagnostic Narrative:

Nebraska Medicaid Comprehensive Orthodontic Pre-Treatment Request Form

Client Name: Enter the full name (first, middle initial, and last name) of the client.

Client's Medicaid: Enter the client's eleven-digit Medicaid identification number.

Birthdate: Enter the client's month, day and year of birth.

Date of Request: Enter the date the submission date for the request.

Provider Name: Enter the dentist name.

Provider Medicaid #: Enter the eleven-digit Medicaid provider number.

Provider Address: Enter the dentist office address (Street, City, State, and Zip).

Provider Phone Number: Enter the dentist office phone number.

Treatment Request:

- In the Maxillary Arch and Mandibular Arch column check the column for the treatment or type of appliance being requested for each arch.
- Number of months of arch adjustments – Enter the number of months of monthly adjustments being requested for each arch.
- Number of months of retention appliance treatment – Enter the number of months of retention visits.
- Fee Column: Enter the dentist usual and customary fee for the treatment requested.

Diagnostic Narrative: Provide information regarding the diagnosis and treatment requested.