

NJ ORTHODONTIC ASSESSMENT TOOL - HLD (NJ-Mod2)

All needed preventive and dental treatment must be completed – attach attestation

Name: _____ Medicaid ID # _____
 Age: _____ Sex: M / F Class/Type of Case: _____
 Treatment: Comprehensive / Interceptive Name of General Dentist: _____
 Name of orthodontist: _____ Billing Provider #: _____

Notes: Follow instructions for completing form found in Newsletter Vol. 22 No. 14. Conditions 1-6A are automatically qualifying conditions and need no further scoring. Indicate with an X when the conditions in 1-6A or 15 are present. Conditions 6B-14 must total 26 or more.

	Condition	Score
1.	Cleft palate deformity (attach description from credentialed specialist)	
2.	Cranio-facial Anomaly (attach description from credentialed specialist)	
3.	Impacted permanent anteriors where extraction is not indicated Note the number of teeth _____	
4.	Crossbite of individual anterior teeth	
5.	Severe traumatic deviations	
6A.	Overjet greater than 9 mm with incompetent lips or reverse overjet greater than 3.5 mm	
6B.	Overjet (mm)	
7.	Overbite (mm)	
8.	Mandibular protrusion (mm) x 5	
9.	Open bite (mm) x 4	
10.	Ectopic eruption (# of teeth x 3)	
11.	Deep impinging overbite (intra-oral photos that demonstrate palatal soft tissue impingement/destruction are required) Score 3 points if present	
12.	Anterior crowding MX _____ MD _____ Total _____ x 5 (score 1 per arch)	
13.	Labiolingual spread (mm)	
14.	Posterior unilateral crossbite (involving molar): Score 4 if present	
15.	Psychological factors affecting development ("X" requires detailed documentation by mental health provider as described per contract of psychological/psychiatric diagnosis, prognosis and that orthodontic correction will improve mental/psychological condition.)	
	TOTAL	

Medical exceptions with score total less than 26 (check one)
 _____ Dental diagnosis _____ Medical diagnosis _____ Clinical significance or functional impairment

For consultant use only:

APPROVED EXCEPTION DENIED