First Review ____
Second Review ____

Models ____
Orthocad ____
Ceph Films ____
X-Rays ____
Photos ____
Narrative ____

DentaQuest USA Insurance Company, Inc.

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

Patient Name: _____ **DOB:** _____ **Medicaid Number:** _____

Abbreviations	CRITERIA	YES	NO
DO	Deep impinging overbite with the palatal impingement of the majority of 1 (one) or more lower incisors.		
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 at least ¾ of a tooth Class II or Class III).		
AX	Anterior maxillary crossbite. (Involves more than two teeth in crossbite or in cases where gingival stripping from the crossbite is demonstrated).		
PX	Posterior transverse discrepancies (involves 3 or more posterior teeth in crossbite, one of which must be a molar).		
PO	Significant posterior openbites. (Not involving erupted teeth or one or two teeth slightly out of occlusion. Openbite must be amenable to orthodontic correction. i.e. not Primary Failure or 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 7-8mm in either the maxillary or mandibular arch		
OJ	Overjet in excess of 9mm. (measure from lingual of the maxillary incisor tip to the lateral of the mandibular incisor tip).		
CDD	Congenial, 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 demonstrating handicapping malocclusion:

_____

_____Note:

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

APPROVED: ❒ **DENIED:** ❒

Reviewed by: _____ **Date:** _____