**Certification of Medical Necessity for Dental Procedures**

**MODIFY TO SUIT YOUR NEEDS. DELETE WHAT DOES NOT APPLY TO YOUR SITUATION. USE OF THIS FORM OFFERS NO GUARANTEE OF ACCEPTABILITY BY MEDICAID OR OTHER PAYORS. DELETE THIS NOTE AFTER CUSTOMIZING.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Record #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Necessity for Radiographs.**

The use of radiographs was medically necessary for identification/evaluation of **(delete what does not apply):**

* clinical evidence of periodontal disease;
* large or deep restorations;
* deep and/or interproximal carious lesions;
* malposed or clinically impacted teeth;
* evidence of dental/facial trauma;
* mobility of teeth;
* sinus tract (“fistula”);
* clinically suspected sinus pathosis;
* growth abnormalities;
* oral involvement in known or suspected systemic disease;
* positive neurologic findings in the head and neck;
* evidence of foreign objects;
* evaluate pain and/or dysfunction of the temporomandibular joint;
* facial asymmetry;
* abutment teeth for fixed or removable partial prosthesis;
* unexplained bleeding;
* unexplained sensitivity of teeth;
* unusual eruption, spacing or migration of teeth;
* unusual tooth morphology, calcification or color;
* unexplained absence of teeth;
* periapical pathology;
* clinical tooth erosion;
* peri-implantitis.

**Medical Necessity for Fluoride:**

In accordance with AAPD guidelines, fluoride was ordered by dentist after a comprehensive oral examination has been performed. The patient is at risk for dental caries.

**Medical Necessity for Sealants due to; indicate all that apply:**

The use of Restorations was indicated due to:

\_\_\_\_\_ deep retentive pits and fissures

\_\_\_\_\_ no radiographic or clinical evidence of proximal caries

\_\_\_\_\_ patient with high risk of caries

\_\_\_\_\_ patient suffering from xerostomia

\_\_\_\_\_ patient undergoing orthodontic treatment

\_\_\_\_\_ stained pit and fissure with numerous appearance of decalcification

**Medical Necessity for Dental Restorations due to; indicate all that apply:**

The use of Restorations was indicated due to:

\_\_\_\_\_ carious lesions clinically visible and detectable with light use of explorer, or;

\_\_\_\_\_ carious lesions clinically visible, but not verified by x-ray or explorer, as patient was uncooperative for exam.

\_\_\_\_\_ prevent and eliminate orofacial disease,

\_\_\_\_\_ prevent and eliminate infection, and

\_\_\_\_\_ prevent and eliminate pain,

\_\_\_\_\_ to restore the form and function of the dentition

\_\_\_\_\_ correct facial disfiguration or dysfunction

**Medical Necessity for Silver Diamine Fluoride due to; indicate all that apply:**

The use of SDF was indicated due to:

\_\_\_\_\_ High caries-risk patients with anterior or posterior active cavitated lesions.

\_\_\_\_\_ Cavitated caries lesions in individuals presenting with behavioral or medical management challenges.

\_\_\_\_\_ Patients with multiple cavitated caries lesions that may not all be treated in one visit.

\_\_\_\_\_ Difficult to treat cavitated dental caries lesions.

\_\_\_\_\_ Active cavitated caries lesions with no clinical signs of pulp involvement.

\_\_\_\_\_ Patients without access to or with difficulty accessing dental care. (EXPLAIN)

**Medical Necessity for Pulpotomy/Stainless Steel Crown due to; indicate all that apply:**

The use of Pulpotomy/Stainless Steel Crown was indicated due to:

\_\_\_\_\_ High caries-risk patient has active cavitated lesions involving multiple tooth surfaces.

\_\_\_\_\_ Extensive decay

\_\_\_\_\_ Deep decay

\_\_\_\_\_ 70% or more of root structure remains

\_\_\_\_\_ Procedure provided more than 12 months prior to normal loss/exfoliation

**Medical Necessity for Root Canal Therapy due to; indicate all that apply:**

The use of Root Canal Therapy was indicated due to:

\_\_\_\_\_ Extensive decay

\_\_\_\_\_ Deep decay

\_\_\_\_\_ Positive pulp vitality test

\_\_\_\_\_ Procedure provided more than 12 months prior to normal loss/exfoliation

\_\_\_\_\_ It is in the patient’s best interest to save the tooth/teeth

\_\_\_\_\_ Have diagnostic pre-operative periapical radiograph(s)

\_\_\_\_\_ Final size of the file to which the canal was enlarged

describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Type of filling material used

describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ If applicable, state the reason that the root canal may appear radiographically unacceptable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Necessity for Extractions for other than 3rd molar site due to; indicate all that apply:**

Extractions for other than 3rd molars was indicated due to:

\_\_\_\_\_ Pain due to impeded eruption

\_\_\_\_\_ Problems associated with poor alignment

\_\_\_\_\_ Risk of damage to adjacent teeth

\_\_\_\_\_ Symptomatic

\_\_\_\_\_ Tooth is non-restorable due to caries

\_\_\_\_\_ Tooth is non-restorable due to the extent of fractured off tooth structure

\_\_\_\_\_ Second or subsequent episodes of pericoronitis (unless the first episode is particularly severe), that cannot be resolved through the use of antibiotics, irrigations, or other topical treatment

\_\_\_\_\_ Tooth is positioned ectopically and prevents the eruption of an adjacent tooth

\_\_\_\_\_ Internal/external resorption of a tooth or adjacent tooth

\_\_\_\_\_ Tooth in aberrant position that is causing bone loss on adjacent tooth/teeth

\_\_\_\_\_ Bicuspid extraction(s) for orthodontic care

Texas Medicaid additional criteria:

\_\_\_\_\_ Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injuries)

\_\_\_\_\_ Intra- or extra-oral radiographs of treatment site(s)

\_\_\_\_\_ If not radiographically evident, intraoral photographs would be appropriate to request; otherwise, intraoral photographs are optional unless requested preoperatively by HHSC or its agent

\_\_\_\_\_ Periodontal probing depths

\_\_\_\_\_ Number of intact walls associated with an angular bony defect

\_\_\_\_\_ Bone graft and barrier material utilized: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Necessity for Protective Stabilization** **due to; indicate all that apply.**

The patient requires Protective Stabilization due to:

\_\_\_\_\_ Patient requires immediate diagnosis and/or urgent limited treatment and cannot cooperate due to emotional and cognitive developmental levels or lack of maturity or medical and physical conditions.

\_\_\_\_\_ Emergent care was needed and uncontrolled movements risk the safety of the patient, staff, dentist, or parent without the use of protective stabilization.

\_\_\_\_\_ A previously cooperative patient quickly became uncooperative during the appointment it was necessary to protect the patient’s safety and help to expedite completion of treatment.

\_\_\_\_\_ Sedated patient may have become uncooperative during treatment.

\_\_\_\_\_ A patient with special health care needs may have experienced uncontrolled movements that could have harmful or significantly interfered with the quality of care.

**Medical Necessity for Space Maintainer due to:**

The use of Space Maintainer was indicated due to:

\_\_\_\_\_ ensure suitable spacing for secondary dentition.

**Medical Necessity for Nitrous Oxide/ Oxygen** **Sedation** **due to; indicate all that apply.**

The use of Nitrous Oxide/ Oxygen sedation was medically necessary due to:

\_\_\_\_\_ a fearful, anxious or obstreperous patient

\_\_\_\_\_ mentally, physically compromised patient

\_\_\_\_\_ patient’s gag reflex interferes with dental care

\_\_\_\_\_ unable to obtain profound local anesthetic effect

\_\_\_\_\_ uncooperative child undergoing a lengthy dental procedure

**Medical Necessity for Non-IV (oral) Conscious Sedation** **due to; indicate all that apply.**

The use of non-IV (oral) conscious sedation was medically necessary due to:

\_\_\_\_\_ a fearful, anxious or obstreperous patient

\_\_\_\_\_ mentally, physically compromised patient

\_\_\_\_\_ patient’s gag reflex interferes with dental care

\_\_\_\_\_ unable to obtain profound local anesthetic effect

\_\_\_\_\_ uncooperative child undergoing a lengthy dental procedure

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

I, undersigned, certify the medical necessity indicated above to be true, accurate and correct.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Signature Date

*Note: Retain signed form in the patient’s record.*