Recipient Name:

# Checklist: Oral Surgery/ Impacted Teeth Medical Necessity

**Instructions:**

MEDICAL NECESSITY DOCUMENTATION REQUIREMENTS PER DHS POLICY (Must be uploaded to the case).

**Requests for authorization must include documentation of evidence of pathology and documentation of one or more of the following criteria, please check which documentation has been submitted:**

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- ☐ **Presence of severe pain or swelling.**

  *NOTE: symptoms for each tooth must be charted in the clinical notes by tooth number and indicate pain level from 1-10, 10 being the worst.*

- ☐ **Recurrent episodes of pericoronitis.**

  *NOTE: provide clinical documentation of history (dates) and treatment completed to resolve each episode.*

- ☐ **Episodes of cellulitis.**

  *NOTE: location must be documented in the clinical notes.*

- ☐ **Episode of abscess formation or untreatable pulpal or periapical pathology.**

  *NOTE: current radiograph must be submitted showing PAP*

- ☐ **Active current periodontal disease due to the position of the third molar and its association with the second molar.**

  *NOTE: Periodontal charting is required if periodontal disease or bony defect is the rationale for extraction. You must submit 6 point periodontal charting however, you are only required to submit charting of the teeth involved.*

  *See example: Periodontal Probing Depths (MB-B-DB) (ML-L-DL): #2 - (747) (747) #15- (747) (747) #18- (747) (747) #31- (747) (747)*

- ☐ **External resorption of the third molar or of the second molar where this would reasonably appear to be caused by the third molar.**

  *NOTE: must be visible on current radiograph*

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- ☐ **Non-restorable carious lesion on a partially erupted third molar or a carious lesion on the distal of the second molar due to the position of the third molar.**

  *NOTE: tooth surfaces where decay is present must be provided in the clinical notes*

- ☐ **Pathological condition such as a dentigerous cyst or other related pathology.**

  *NOTE: must be visible on radiograph*

- ☐ **Copies of current radiographs (must include each tooth to be extracted) of diagnostic value, containing patient identifiers and date of exposure. Do not submit original X-rays; they could be lost and compromise the member's care. Faxed radiographs are not accepted.**

  *NOTE: we are not able to accept patient's name as a file name. All radiographs submitted must include exposure date, and patient's full name on the radiograph.*

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## Attestation

THIS CHECKLIST DOES NOT REPLACE CLINICAL DOCUMENTATION. CLINICAL DOCUMENTATION MUST BE SUBMITTED AND COMPLETED BY ORDERING DENTIST WITH CREDENTIALS INCLUDED.

*NOTE: Please be advised that the clinical rationale/medical necessity information must be captured within the physical record (written documentation) and not solely entered as a case note.*

By checking "I agree" and typing my name in the "Electronic Signature" field I understand that I am electronically signing this form. In addition, I attest and certify that I have verified the profile change against an acceptable form of identification and that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. Mg Stat. 325L.07) ***** You MUST attach documentation to support the answers given in the questionnaire *****

- ☐ I agree

____________________________ ____________________

Signature Date

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Print Name