New York State Medicaid Orthodontic Program

Frequently Asked Questions (FAQs)

Prior Approval requests:

1. **Q: For orthodontic services, is there an expiration date for prior approval?**
   A: Yes. The expiration date is indicated on the approval. The approved services **must** be provided within the approved period of service.

2. **Q: Will the approvals issued by NYCORP for initial placement still be honored?**
   A: No. The transition period for automatically issuing approvals for NYCORP cases has ended. All requests for initiation of orthodontic treatment need to be submitted to the patient's benefit administrator (FFS or MMC plan).

3. **Q: What will the process be for current NYC orthodontic patients regarding the annual review?**
   A: The provider will need to obtain PA for second and third year treatment and retention from Albany. Documentation of progress and medical necessity is required. See page 56 of the Dental Policy and Procedure Code Manual which can be downloaded from the internet at:
   https://www.emedny.org/ProviderManuals/Dental/index.aspx

4. **Q: What form should be used to request a prior approval for orthodontic treatment?**
   A: For beneficiaries covered through FFS: Prior approval requests must be submitted on the paper EMEDNY361401 (which must be obtained from CSC) or electronically in a HIPAA compliant 278 transaction such as ePACES.
   PA request form (EMEDNY361401):
   https://www.emedny.org/info/phase2/PDFS/Dental_PA.pdf

5. **Q: When does an orthodontic office request second year care for a FFS patient who has an existing PA for first year treatment?**
   A: FFS requires PA for second and third year treatment and retention. If the patient was approved through FFS all prior approvals and payments will continue FFS to the completion of the approved course of orthodontic treatment. Near the end of the approved period of service, a new prior approval request will need to be submitted for approval for continuation of care.
   See page 56 of the Dental Policy and Procedure Codes Manual
   https://www.emedny.org/ProviderManuals/Dental/index.aspx

6. **Q: For orthodontic patients with managed care coverage that are in the middle of treatment, will FFS pay only through the end of the current year of treatment that was approved or does FFS pay to complete the full 3 years of orthodontic treatment plus retention care?**
   A: For beneficiaries, who were approved for orthodontic treatment through FFS, Medicaid will continue to provide active orthodontic coverage through FFS for the duration of treatment and retention provided patient is eligible on the date of service.

7. **Q: How do we submit prior approval requests for annual reviews?**
   A: You can submit on paper or you can upload all records electronically on ePACES. Documents stored in a digitized format (x-rays, treatment plans, charting, photographs, etc.) can be submitted as electronic attachments to dental prior approval requests when submitted through ePACES. This enhanced feature is currently only available through ePACES. The following file formats are currently supported: JPEG; TIF; PNG: and GIF. Call Computer Science Corporation (CSC) at 1-800-343-9000 for more information. CSC will provide necessary technical help to get you started. In addition, CSC representative can visit your office to provide additional training, if necessary.

   Instructions for Obtaining Prior approval are available online: https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental_PA_Guidelines.pdf

8. **Q: What documentation do we need to submit for annual reviews?**
   A: Unless approval was issued through Albany, we need copies of all previous authorizations related to the case (i.e. BD101A, NYCORP authorization letter, transfer papers, approvals for 2nd or 3rd year, etc.) that were issued by NYCORP;

   Photographs which accurately show the current status of orthodontic treatment. If treatment was authorized through NYCORP, Albany does not have copies of the original records. Copies of the pre-treatment photographs, if available, should be included to document treatment progress. If the request is for de-banding and retention (D8680), photographs should show that treatment is satisfactorily completed prior to the removal of appliances. **Appliances should not be removed until approval is received from Albany**;

   To allow for continuity of billing and treatment, the correct "PERIOD OF SERVICE" must be provided, for example, if last quarter of first year care was paid on 2/15/13, request for second year should indicate – "Requesting second year care, Dates: 5/15/13 – 5/15/14" on Prior Approval form (paper submission) or Provider Comments section (electronic submission); and,

   Any other information or narrative report that you feel is relevant (patient compliance problems, unusually difficult treatment, surgical or eruption delays, etc.).

9. **Q: Why can't we request a backdated prior approval beyond 90 days?**
   A: The State requires that claims must be submitted within 90 days of the date of service. Therefore, prior approvals can only be backdated up to that point as well. Prior Approvals will only be backdated on a rare exception basis (billing and PA errors are NOT a valid reason) and only then within 90 days of the date of service. The rules for backdating prior approvals are spelled out in the provider manual on page 16.

10. **Q: How does an orthodontic office request a change in the dates for an existing prior approval?**
    A: Submit a "PA Change Request" form to Computer Sciences Corporation (CSC).
    PA change request form and instructions are available online:
    https://www.emedny.org/info/phase2/PDFS/PA%20Change%20Request%20Form-eMedNY.pdf
    https://www.emedny.org/info/phase2/PDFS/Prior%20Approval%20Change%20Request%20Form%20Instructions.pdf
    Provider fax cover sheet:
    https://www.emedny.org/info/phase2/PDFS/Provider_Fax_Cover_Sheet.pdf

Billing:

11. **Q: What 90-day delay reason code would be used when billing the limited extended coverage for orthodontia treatment? (DOH instructs to wait until the end of the billing period.)**
    A: In the specific case of submitting claims for the "limited extended coverage" benefit which is beyond 90 days from the date of service, reason code #3 should be used.

    For any other situations, providers should choose the appropriate delay reason code that applies to the specific claim. The list is available in the General Billing Guidelines at: https://www.emedny.org/ProviderManuals/AllProviders/index.aspx

12. **Q: Is limited extended coverage available while client has guarantee only coverage?**
    A: No. The limited extended coverage is for clients who have lost ALL eligibility for Medicaid. While in guarantee status, the client is still eligible for plan services, so you will be billing the managed care plan during the guarantee. In order for limited extended coverage to apply, the orthodontic treatment must have begun prior to the guarantee status.

13. **Q: Our claims are getting denied due to the 90-day rule, how do I bill to receive payment?**

    A: All Medicaid providers are responsible for submitting their claims in a timely manner as per the instructions in the Provider Manual. The 90 day submission policy must be followed and the appropriate reason code for that specific claim used.

    Please refer to the March 2012 Medicaid Update article at:

    http://www.health.ny.gov/health_care/medicaid/program/update/2012/march12mu.pdf

    Medicaid General Billing Guidelines are in your provider manual https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf.

    Refer to 90 day FAQ's: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/FAQs_on_delayed_claims.pdf

14. **Q: How do I check client's eligibility?**
    A: The provider is responsible for checking the patient's Medicaid eligibility at **EVERY** appointment.

    Instructions are available online: https://www.emedny.org/providermanuals/5010/MEVS%20Quick%20Reference%20Guides/5010_MEVS_Methods.pdf

15. **Q: It is our office policy to bill all of our non-Medicaid patients for broken or missed appointments. Can we bill Medicaid patients for missed or broken appointments too?**
    A: Absolutely NOT. The Federal Government will only reimburse for identifiable items or services, of which a broken appointment is neither. They have also expressed the opinion that the administrative and overhead costs of broken or missed appointments have already been factored in the reimbursement for the procedure.
    Refer to pages 13-14 and 53 of the dental provider manual.

16. **Q: How often does Medicaid pay for progress photographs?**
    A: Medicaid requires progress photographs for annual reviews; therefore, it will be reimbursed every year i.e. at the end of first, second and third year care and final photographs prior to debanding.

17. **Q: We have approval from Managed Care and patient is currently under active treatment, what do I do if patient loses Medicaid coverage?**
A: Call 1-800-342-3005, option #2 to obtain the patient's last date of eligibility. You can bill the "limited extended coverage" using procedure code D8999 on a **paper claim**, with a copy of the approval(s) and remittance statement(s) from the Managed Care plan. When eligibility is lost after active orthodontic treatment has been initiated, fee-for service Medicaid will provide either two quarter of active treatment or one quarter and retention or retention alone. Be sure to provide a narrative stating what stage of treatment the patient is currently in. For example:

"We are submitting this claim for the "limited extended coverage" benefit for the fourth quarter first year care and first quarter second year care."

Refer to page 53 of the dental provider manual.

Clinical:

18. **Q: Is there a cutoff age for orthodontia services?**
A: Orthodontic treatment **must** be approved and active therapy begun **prior** to the recipient's 21st birthday.

19. **Q: My patient lost a retainer. Can I provide a new one for her / him?**
A: A retainer can be replaced for up to 1 year after placement of the original retainer as long as the client is Medicaid eligible. Use procedure code D8692 (allowed once in a lifetime and includes both arches if necessary). Submit your claim for a replacement retainer (D8692) on paper, with the following documentation:

- Copy of a signed statement from patient/parent explaining the circumstances;
- Copy of patient's treatment record indicating the date that the appliance was delivered; and,
- Copy of dental laboratory bill, if available.

20. **Q: How do we fill out HLD form?**
A: Each case is professionally and individually evaluated. Please fill the HLD index out to the best of your ability following the guidelines. Please make sure

that the values of the index are substantiated by the supporting radiographs and photographs.
HLD Index form and instructions are available online:
https://www.emedny.org/ProviderManuals/Dental/PDFS/HLD_Index_NY.pdf

21. **Q: How do we transfer a case when a parent wants to seek orthodontic treatment at our office?**
A: If the patient has been treated through FFS Medicaid Program, you will need to submit a notarized statement from a parent/guardian stating reason (s) for transfer and submit a prior approval request to CSC along with current photographs and your treatment plan.

22. **Q: We provided Interceptive Phase I treatment under fee-for-service Medicaid and now patient is ready for comprehensive treatment. Is comprehensive treatment "grandfathered-in" for managed care patients?**
A: No. Comprehensive orthodontic treatment represents a new phase of treatment with a different treatment plan which requires an evaluation of the **current** conditions to determine if there is a severe physically handicapping malocclusion. A new prior approval will need to submitted and reviewed and a new determination made by the benefit administrator (either fee-for-service or managed care) for that patient.

23. **Q: What is the protocol for requesting surgical evaluation and approval for this patient in addition to orthodontic treatment? Or do I wait till he is close to completion prior to surgical request?**
A: The orthodontist and surgeon need to work closely to develop and implement a coordinated treatment plan. If the patient has fee-for-service Medicaid coverage, the orthognathic surgery can be provided without prior approval from Medicaid if surgery is a medical necessity and was part of the original treatment plan for orthodontic treatment submitted by the orthodontist. Be sure that you have an active prior approval for the initiation or continuation of comprehensive orthodontic treatment from Albany.

If the patient is enrolled in a Managed Care plan, the plan is responsible for the surgical component of treatment even if the orthodontic phase is administered through the fee-for-service program.

Managed Care:

24. **Q: What standard is used for an adequate network of orthodontists in Managed Care?**
A: The network requirement is a minimum of 2 orthodontists per county. This is a minimum requirement dependent upon the geographic accessibility to members residing in the counties.

In some areas of the state there may be a lack of orthodontists making this provider type unavailable to members. Where orthodontists are unavailable or not geographically accessible to members in the county the analysis will determine whether there are orthodontists within 30 minutes/30 miles of members.

25. **Q: As a provider do you enroll with the different insurance (Metro Plus, Fidelis, etc.) or only to the vendor (Dentaquest or Healthplex)?**
    A: You have to enroll with each plan separately. Please contact the individual plan for more information.

26. **Q: Can each plan choose where to send orthodontic cases?**
    A: The plans can assign a beneficiary to one of their network providers; however, the patient or another orthodontist of the patient's choosing can request re-assignment as long as the new orthodontist is also in the plans network.

27. **Q: If we only participate with the FFS Medicaid Program and aren't participating with any of the MMC plans, will we be able to continue as usual with any new FFS patient after 10/1/12? Can we submit prior approval requests to initiate orthodontic treatment or can we no longer see any new patients?**
    A: You can continue to accept All new clients that are NOT enrolled in Medicaid managed care and continue to submit prior approval requests using the procedures and policy outlined in the "Dental Policy and Procedure Manual."

28. **Q: Are all MMC plans providing Orthodontia Services?**
    A: Yes, as of October 2012, all Medicaid managed care plans and HIV/SNPS will be covering the benefit.

29. **Q: Will general dentists and pediatric dentists be able to perform orthodontic treatment under managed care? Or is this only available for orthodontists?**
    A: The services a general or pediatric dentist may provide to an MMC plan's members will be articulated in the provider contract.

30. **Q: What is the MCO's turnaround time to process a request for orthodontia? I thought it was 3 business days for dental. Is it longer for orthodontia?**
    A: Utilization review determinations for the preauthorization of services are required to be made within 3 business days, or as the condition requires, from receipt of all of the necessary information.

Miscellaneous:

31. **Q. I am currently a certified orthodontist renting a space in a general practice office. Can I treat Medicaid patients in that office?**
    A: Orthodontists must be enrolled in the FFS Medicaid program to receive FFS payment. Ownership and disclosure requirements must be met as a condition of enrollment and ongoing participation. Renting space is allowed for FFS providers and the provider must meet all professional and Medicaid standards and requirements including record keeping, patient care and billing.

32. **Q. When will the grace period end for NYC providers to submit a claim without an eMedNY prior approval number for continuing care (D8670)?**
    A. September 30, 2013. Effective for dates of service on and after October 1, 2013, the 11 digit eMedNY prior approval number will be required on all claims for D8670 or the claim will be denied automatically.

33. **Q. Where can I find more information?**
    A. The following is a list of more information and resources:

New York State Medicaid Dental Provider Manual (Policy and Procedure Codes, Fee Schedule, Billing Guidelines, HLD Index Report, Prior Approval Guidelines):

https://www.emedny.org/ProviderManuals/Dental/index.aspx

Medicaid Managed Care Vendor Contact Information:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/dental_vendor_contact_information.pdf

Training for Providers (Webinars and in-person):

https://www.emedny.org/training/index.aspx

Evaluation for Severe Physically Handicapping Malocclusion Webinar Presentation (August 23, 2012):

https://www.emedny.org/ProviderManuals/Dental/PDFS/HLD_Index_Presentation_8-23-12.pdf

e-Dental Webinar Presentation (July 25, 2012):
https://www.emedny.org/ProviderManuals/Dental/PDFS/eDentalWebinar_7-25-12.pdf

Transition of Dental and Orthodontia Coverage from Fee for Service to Medicaid Managed Care Webinar Presentation (June 12, 2012):

http://www.health.ny.gov/health_care/managed_care/docs/transition_dental_orthodontia _coverage.pdf

Fee for service billing questions, call CSC at 1-800-343-9000

Fee for service orthodontic prior approval, email: Ortho@health.ny.gov

Medicaid Managed Care access, availability, care delivery and plan review issues, email: managedcarecomplaint@health.ny.gov