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Clinical Criteria Revisions to the New York State Medicaid Program Dental Policy and Procedure Code Manual

I. INTRODUCTION

Effective January 31, 2024, the clinical criteria for coverage of root canals, crowns, replacement dentures and dental implant contained within the New York State Medicaid Program Dental Policy and Procedure Code Manual ("Dental Manual") will be changed to allow for expanded coverage of previously limited dental services. These changes apply to: (1) Fee-for-Service (FFS); and (2) and Medicaid Managed Care Organizations (MCOs).

These changes represent an expansion in coverage from prior Dental Manuals. The aim of these revisions is to maintain a member's natural dentition whenever clinically appropriate. As reflected throughout this document, the updated Dental Manual provides revisions to the coverage policies for crowns, root canals, and dental implants and the purpose of these changes is to expand coverage of these dental services when such dental services are medically necessary.[1] Additionally, the updated Dental Manual contains revisions to the prosthodontics policy that removes limitations on when replacement prosthodontics will be covered.

Please note that MCOs and fee-for-service providers are required to use the criteria as set forth in the Dental Manual and may not impose additional or more restrictive criteria. Root canals, crowns, replacement dentures and dental implants are now covered benefits. Prior authorization requests for these services may NOT be denied on the basis that they are not covered services. Enrollees are entitled to external appeal rights.

The purpose of this document is to serve as a guide to assist providers and MCOs in understanding the updated clinical criteria for root canals, crowns, replacement dentures and dental implants.

This guide contains both the revisions as set forth in the Dental Manual as well as commentary about the revised clinical criteria for each service. In addition to providing

[1] "Medically necessary" is set forth as "medical, dental and remedial care, services and supplies…" which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap…" New York State Social Services Law § 365-a(2).

this document, the New York State Department of Health ("NYS DOH") intends to hold a webinar on this material, which will be followed by an opportunity for a Q &A. Notice of the webinar will be provided to providers and Plans no later than January 2, 2024 .

II. REVISED SECTIONS OF THE DENTAL MANUAL

A. Services Not Within the Scope of the Medicaid Program

i. ***Introduction:*** The section entitled "Services Not Within the Scope of the Medicaid Program" sets forth the services that are not within the scope of the Medicaid Program. The notable change to this section, effective January 31, 2024 , is that crown lengthening MAY now be covered in certain circumstances. *Please note:* all specific references to crowns and endodontics have been removed from this this introductory section of the Dental Manual. Please directly refer to the Crowns (Section III) and Endodontics (Section IV) sections for the revised clinical criteria for crowns and root canals.

ii. ***Revisions:*** The revised "Services Not Within the Scope of the Medicaid Program" section will read:

Services Not Within the Scope of the Medicaid Program

These services include but are not limited to:

- Fixed bridgework, except for cleft palate stabilization, or when a removeable prosthesis would be contraindicated;
- Immediate full or partial dentures;
- Crown lengthening, except when associated with medically necessary crown or endodontic treatment;
- Dental work for cosmetic reasons or because of the personal preference of the member of provider;
- Periodontal surgery, except when associated with implants or implant related services;

- Gingivectomy or gingivoplasty, except for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;

- Adult orthodontics, except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts;

- Placement of sealants for members under 5 or over 15 years of age;

- Improper use of panoramic images (D0330) along with intraoral complete series of images (D0210).

iii. ***Commentary***

- Crown lengthening will ONLY be covered when associated with a covered crown and/or root canal procedure. ***See*** Section III.

- All requests for coverage of a crown lengthening should include a **complete treatment plan addressing all areas of pathology.**

- Coverage of a crown lengthening should be requested at the same time as a request for coverage of a crown and/or a root canal.

- If the need for crown lengthening is discovered during a procedure then providers should refer to p. 18 of the Dental Manual, which states:

  If a change is needed or there exists a disagreement with a prior approval review and you would like to challenge a determination rendered by the DOH on an existing finalized prior approval, a request may be submitted with supporting documentation and a detailed report using a "Prior Approval Change Request Form". This form may be submitted pre-operatively or post-operatively. If the requested change is submitted post-operatively a copy of the treatment notes should be included with the request.

- A Prior Approval Change Request Form can be obtained by clicking on the link below or by calling eMedNY at 1-800-343-9000. eMedNY link:

B. Essential Services

i. Introduction: Section V(3) sets forth the essential services that are within the scope of the Medicaid Program. There are notable changes to this section,

effective January 31, 2024, including removal of the discussion relating to the presence or absence of eight (8) points of contact in a member's dentition, which has been moved to each of the categories of services where it applies.

*ii. **Revisions:*** The revised "Essential Services" section will read:

When reviewing requests for services the following guidelines will be used:

Caries index, periodontal status, recipient compliance, dental history, medical history and the overall status and prognosis of the entire dentition, among other factors, will be taken into consideration when determining medical necessity. Treatment is considered appropriate where the prognosis of the tooth is favorable. Treatment may be appropriate where the total number of teeth which require or are likely to require treatment is not considered excessive or when maintenance of the tooth is considered essential or appropriate in view of the overall dental status of the recipient.

Treatment of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable. Claims submitted for the treatment of deciduous cuspids and molars for children ten (10) years of age or older, or other deciduous incisors in children five (5) years of age or older will be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these restorations. Extraction of deciduous teeth will only be reimbursed if injection of a local anesthetic is required.

As utilized in this Manual eight (8) posterior points of contact refers to four (4) maxillary and four (4) mandibular (molars/premolars) in natural or prosthetic functional contact with each other.

For the criteria to be used when determining medical necessity for Crowns, Endodontics, Prosthodontics, and Implant Services, refer to the following specific sections of the Manual:

- Crowns (Section III LINK);
- Endodontics (Section IV LINK);
- Prosthodontics (Section VI LINK);
- Implant Services (Section VII LINK).

iii. Commentary

- The former provision requiring requests to be reviewed based upon the presence or absence of eight (8) points of natural or prosthetic occlusal contact has been REMOVED from the "Essential Services" section of the Dental Manual.

- Notably, root canals and crowns SHOULD NOT be denied solely on the basis that a member has eight (8) or more points of natural or prosthetic occlusal contact.

- Please refer to the Crowns (section cite) and Endodontics (section cite) sections for the revised clinical criteria for root canals and crowns.

C. RESTORATIVE D2000 – D2999 (CROWNS – SINGLE RESTORATION ONLY)

i. ***Introduction:*** Section III sets forth the clinical criteria for the coverage of crowns within the scope of the Medicaid Program. The notable changes to this section, effective January 31, 2024, include expanded coverage for crowns, revisions to the presence or absence of eight (8) or more natural or prosthetic contact and changes to the provision regarding functional occlusion.

ii. ***Revisions***: The revised "Crowns" section will read:

> The materials used in the fabrication of a crown (e.g., all-metal, porcelain, ceramic, resin) is at the discretion of the provider. The crown fabricated must correctly match the procedure code approved on the Prior Approval.
>
> Crowns include any necessary core buildups.
>
> Crowns for members under the age of 21 will be covered when medically necessary. In determining whether a requested crown is medically necessary, the following factors may be considered:
>
> - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
> - The tooth is not routinely restorable with a filling.
>
> Crowns for members *21 years of age and over* will be covered when medically necessary. In determining whether a crown is medical necessary, the following factors may be considered:
>
> - There is a documented medical condition which precludes extraction.
> - The tooth is a critical abutment for an existing or proposed prosthesis.
> - If the tooth is a posterior tooth, the following additional factors may be considered:
>   - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.

- The tooth is not routinely restorable with a filling.
- There are eight (8) or more natural or prosthetic points of contact present.
- If the posterior tooth is a molar, treatment of the molar is necessary to maintain functional or balanced occlusion of the patient's dentition.
- Consideration for a third (3rd) molar will be given if the third (3rd) molar occupies the first (1st) or second (2nd) molar position.
- Note: Requests for treatment on unopposed molars MUST include a narrative documenting medical necessity.

➢ If the tooth is an anterior tooth, the following additional factors may be considered:

- The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
- The tooth is not routinely restorable with a filling.

iii. Commentary

1. General

- The bullet points contained in the "Crowns" section of the Dental Manual should all be considered when formulating a treatment plan but are NOT mutually exclusive, meaning that not all factors must be satisfied for a crown to be covered.

- A crown will be covered where there are eight (8) or more points of natural or prosthetic contact unless there is a documented indication to extract the tooth.

- Crown lengthening will be covered when associated with a covered crown.

    - **Note:** coverage of crown lengthening should be requested simultaneously with a request for coverage of a crown.

    - Please refer to D4249 of Section V Periodontics of the Dental Manual for the new billing codes associated with crown lengthening.

2. Crown Coverage Where Extraction Is Precluded Due to a Medical Condition

- A crown will be covered if the member has a documented medical condition which precludes extraction of the tooth.

    - *Example:* A member needs a crown on a pre-molar but has fewer than eight (8) points of contact. The member also has a

documented medical condition that makes extraction of the pre-molar dangerous. Due to the medical condition, a crown on the member's pre-molar will be covered.

- A crown will be considered for coverage on a member's third (3rd) molar if the member has a documented medical condition which precludes extraction even if: (1) the third (3rd) molar is in the third (3rd) molar position or (2) the third (3rd) molar is unopposed.

    - **Note:** A narrative documenting the medical necessity of a crown on a member's third (3rd) molar is not required, even if the third (3rd) molar is unopposed, if the patient has a documented medical condition that precludes extraction.

- If a member has a medical condition that precludes extraction of a tooth, NYS DOH may request supporting documentation of the member's medical condition from the member's treating physician.

3. Crown Coverage Where Extraction is Precluded Due to the Tooth Being a Critical Abutment

- A crown will be covered where the tooth needing the crown is a critical abutment for an existing or proposed prosthesis. [2]

    - *Example:* A member needs a crown on a molar but has fewer than eight (8) points of contact. However, the molar is a critical abutment to a prospective prosthesis. Due to the molar being a critical abutment, the crown on the member's molar will be covered.

- A crown will be covered on a member's third (3rd) molar if the member's third (3rd) molar is a critical abutment even if: (1) the third (3rd) molar is in the third (3rd) molar position; or (2) the third (3rd) molar is unopposed.

    - **Note:** A narrative documenting the medical necessity of a crown on a member's third (3^{rd}) molar is not required, even if the third (3rd) molar is unopposed, if the member's third (3rd) molar is a critical abutment.

[2] A critical abutment is a tooth or implant that supports a fixed or removable prosthesis, to the extent that the retention, stability and/or function of the prosthesis would be severely compromised without it.

4. Occlusion

- Coverage of a crown on a molar WILL be considered if the molar is necessary to maintain balanced or functional occlusion of the patient's dentition.

  Note: If a patient has eight (8) or more points of contact, coverage of a crown WILL NOT be denied under the justification that the molar is not "necessary to maintain balanced or functional occlusion of the patient's dentition".

- For anterior teeth (teeth # 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27), crowns will be covered where: (1) the periodontal status is favorable; (2) member compliance is favorable; (3) the status and prognosis of the tooth is favorable; and (4) where the tooth is not routinely restorable with a filling.

- A request for a crown on an <u>unopposed</u> molar (teeth #'s 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32) must include a narrative documenting the medical necessity of restoration as opposed to extraction.

  - *Example:* a crown on an unopposed molar is medically necessary because extraction of the molar could cause osteoradionecrosis of the jaw or could cause adjacent teeth to drift or rotate.

- In order for a molar to be considered unopposed, it must be entirely unopposed as determined by radiographic evidence.

  - *Example:* Tooth #14 is typically in occlusion with teeth #19 and #20. However, radiographic evidence demonstrates that tooth #14 is unopposed because both tooth #19 and tooth #20 are missing. In contrast, tooth #14 is opposed if only tooth #19 or only tooth #20 is missing.

- A request for a crown on an unopposed molar does NOT require a narrative documenting medical necessity if a patient's documented medical condition precludes extraction.

- A request for a crown on an unopposed molar does NOT require a narrative documenting medical necessity if the molar is a critical abutment for an existing or prospective prosthesis.

- A request for a crown on an unopposed anterior tooth (teeth # 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27) or an unopposed pre-molar

(teeth #4, 5, 12, 13, 20, 21, 28 and 29) do NOT require a narrative documenting medical necessity.

D. ENDODONTICS D3000 – D3999

i. ***Introduction:*** Section IV sets forth the clinical criteria for the coverage of endodontics (referred to as "root canals" hereinafter) within the scope of the Medicaid Program. The notable changes to this section, effective January 31, 2024 , include expanded coverage for root canals, revisions to the provision discussing the presence or absence of eight (8) or more natural or prosthetic contact and changes to the provision regarding functional occlusion.

ii. ***Revisions:*** The revised "Endodontics" section will read:

Root canal therapy for members under the age of 21 will be covered when medically necessary. In determining whether a requested root canal is medically necessary, the following factors may be considered:

- The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
- The tooth is not routinely restorable with a filling

Root canal therapy for members *21 years of age and* over will be covered when medically necessary. In determining whether requested endodontic treatment is medically necessary, the following factors may be considered:

- There is a documented medical condition which precludes extraction of the tooth.
- The tooth is a critical abutment for an existing or proposed prosthesis.
- If the tooth is a posterior tooth, the following additional factors may be considered:
    - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
    - There are eight (8) or more natural or prosthetic posterior points of contact present.

- If the posterior tooth is a molar, treatment of the molar is necessary to maintain functional or balanced occlusion of the patient's dentition.
- Consideration for a third molar will be given if the third (3rd) molar occupies the first (1st) or second (2nd) molar position.
- Note: Requests for treatment on unopposed molars must include a narrative documenting medical necessity.

- If the tooth is an anterior tooth, the following additional factors may be considered:
  - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.

iii. Commentary

1. General

- The bullet points contained in the "Endodontics" section of the Dental Manual should all be considered when formulating a treatment plan but are NOT mutually exclusive, meaning that not all factors must be satisfied for a root canal to be covered.

- A root canal will be covered where there are eight (8) or more points of natural or prosthetic contact unless there is a documented indication to extract the tooth.

- Crown lengthening will be covered when associated with a covered crown and/or covered root canal procedure.

  - **Note:** coverage of crown lengthening should be requested simultaneously with a request for coverage of a crown and/or root canal procedure.

  - Please refer to D4249 of Section V Periodontics of the Dental Manual for the new billing codes associated with crown lengthening.

2. Root Canal Coverage Where Extraction Is Precluded Due to a Medical Condition

- A root canal will be covered if the member has a documented medical condition which precludes extraction of the tooth.

  - *Example:* A member needs a root canal on a pre-molar but has fewer than eight (8) points of contact. The member also has a documented medical condition that makes extraction of

the pre-molar dangerous. Due to the medical condition, a root canal on the member's pre-molar will be covered.

- A root canal will be covered on a member's third (3rd) molar if the patient has a documented medical condition which precludes extraction even if: (1) the third (3rd) molar is in the third (3rd) molar position; or (2) the third (3rd) molar is unopposed.

    - **Note:** A narrative documenting the medical necessity of a root canal on a patient's third (3rd) molar is not required, even if the third (3rd) molar is unopposed, if the patient has a documented medical condition that precludes extraction.

- If a member has a medical condition that precludes extraction, NYS DOH may request supporting documentation of the member's medical condition from the member's treating physician.

3. Root Canal Coverage Where Extraction is Precluded Due to the Tooth Being a Critical Abutment

- A root canal will be covered where the tooth is a critical abutment for an existing or proposed prosthesis.

    - *Example:* A member needs a root canal on a molar but has fewer than eight (8) points of contact. However, the molar is a critical abutment to a prospective prosthesis. Due to the molar being a critical abutment, the root canal on the member's molar will be covered.

- A root canal will be covered on a member's third (3rd) molar if the patient's third (3rd) molar is a critical abutment even if: (1) the third (3rd) molar does NOT occupy the first (1st) or second (2nd) molar position; or (2) the third (3rd) molar is unopposed.

    Note: A narrative documenting the medical necessity of a root canal on a member's third (3rd) molar is not required, even if the third (3rd) molar is unopposed, if the patient's third (3rd) molar is a critical abutment.

4. Occlusion

- Coverage of a root canal on a molar WILL be considered if the molar is necessary to maintain balanced or functional occlusion of the patient's dentition.

Note: If a patient has eight (8) or more points of contact, coverage of a root canal WILL NOT be denied under the justification that the molar is not "necessary to maintain balanced or functional occlusion of the patient's dentition".

- For anterior teeth (teeth #s 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27), root canals will be covered where: (1) the periodontal status is favorable; (2) member compliance is favorable; and (3) the status and prognosis of the tooth is favorable.

- A request for a root canal on an unopposed molar (teeth # 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32) must include a narrative documenting the medical necessity of restoration as opposed to extraction.

    - *Example:* a root canal on an unopposed molar is medically necessary because extraction of the molar could cause osteoradionecrosis of the jaw or could cause adjacent teeth to drift or rotate.

- In order for a molar to be considered unopposed, it must be entirely unopposed as determined by radiographic evidence.

    - *Example:* Tooth #14 is typically in occlusion with teeth #19 and #20. However, radiographic evidence demonstrates that tooth #14 is unopposed because both tooth #19 and tooth #20 are missing. In contrast, tooth #14 is opposed if only tooth #19 or only tooth #20 is missing.

- A request for a root canal on an unopposed molar does NOT require a narrative documenting medical necessity if a member's documented medical condition precludes extraction.

- A request for a root canal on an opposed molar does NOT require a narrative documenting medical necessity if the molar is a critical abutment for an existing or prospective prosthesis.

- A request for a root canal on an unopposed anterior tooth (teeth # 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 and 27) or unopposed pre-molars (teeth #4, 5, 12, 13, 20, 21, 28 and 29) do NOT require a narrative documenting medical necessity

E. PROSTHODONTICS (Removable) D5000 – D5899

i. ***Introduction:*** Section VI sets forth the criteria for the coverage of replacement prosthodontics (referred to as "replacement dentures" hereinafter) within the scope of the Medicaid Program. The notable changes to this section, effective January 31, 2024, include revisions to the documentation required by the member's dentist and the removal of the requirement that the member provide a physician letter.

ii. ***Revisions:*** The revised "Prosthodontics" section will read:

> Full and/or partial dentures are covered by Medicaid when they are determined to be medically necessary, including when necessary to alleviate a serious condition or one that is determined to affect employability. This service requires prior approval.
>
> Complete dentures and partial dentures, whether unserviceable, lost, stolen, or broken will not be replaced for a minimum of eight (8) years from initial placement except when determined to be medically necessary by the Department or its agent. Prior approval requests for replacement dentures prior to eight (8) years must include a completed Form signed by the patient's dentist, explaining the specific circumstances that necessitates replacement of the denture. If replacement dentures are requested within the eight (8) year period after they have already been replaced once, then the dentist's supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.
>
> **General Guidelines for All Removable Prosthesis:**
>
> - Requests for partial dentures will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular teeth.
>
> - Complete and/or partial dentures will be approved only when the existing prosthesis is not serviceable and cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be reimbursed when such procedures are performed in addition to a new prosthesis for the same arch within six (6) months of the delivery of a new prosthesis. Only "tissue conditioning" (D5850 or D5851) is payable within six (6) months prior to the delivery of new prosthesis.
>
> - Six (6) months of post-delivery care from the date of insertion is included in the reimbursement for all newly fabricated prosthetic appliances. This included rebasing, relining, adjustments, and repairs.

- Cleaning of removable prosthesis or soft tissue not directly related to natural teeth is not a covered service. Prophylaxis and/or scaling and root planning is only payable when performed on natural dentition.

- "Immediate" prosthetic appliances are not a covered service. An appropriate length of time for healing should be allowed before taking a final impressions. Generally, it is expected that tissue will need a minimum of four (4) to six (6) weeks for healing. Claims for denture insertion occurring within four (4) weeks of extraction(s) will pend for professional review.

- Claims are not to be submitted until the denture(s) are completed and delivered to the member. The "date of service" used on the claim is the date that the denture(s) are delivered. If the prosthesis cannot be delivered or the member has lost eligibility following the date of the "decisive appointment" claims should be submitted following the guidelines for "Interrupted Treatment".

- Medicaid payment is considered payment in-full. Except for members with a "spend down," members cannot be charged beyond the Medicaid fee. Deposits, down-payments, or advance payments are prohibited.

iii. Commentary

- The supporting documentation detailing the preventative measures implemented to prevent future loss of a member's denture(s) is ONLY required when a subsequent request for replacement denture(s) is made within eight (8) years of the member's prior request for denture(s).

- The prior requirement that a member's physician provide documentation explaining how replacement denture(s) would alleviate the member's serious health condition or improve employability has been REMOVED from the prosthodontics section of the Dental Manual.

- MCOs and Fee-for-Services providers are REQUIRED to submit NYS DOH Prior Authorization Form: Justification of Need for Replacement Prosthesis with ALL requests for replacement denture(s).

  Note: MCOs and Fee-for Service providers are directed to complete the entirety of Prior Authorization Form prior to submitting it to NYS DOH.

- The Prior Authorization Form DOES NOT need to be notarized, and MCOs and Fee-for-Service providers cannot impose additional criteria other than what is provided on NYS DOH Prior Authorization Form.

F. IMPLANT SERVICES D6000 – D6199

i. ***Introduction:*** Section VIII sets forth the clinical criteria for the coverage of dental implants within the scope of the Medicaid Program. The notable changes to this section, effective January 31, 2024 include removal of the requirement of a letter from the member's physician and clarification on coverage of single tooth implants.

ii. ***Revisions:*** The revised "Implant Services" section will read:

> Dental implants, including single implants, and implant related services will be covered by Medicaid when medically necessary. Prior approval requests for implants must have supporting documentation from the patient's dentist. The patient's dentist's office must submit a completed Form documenting, among other things, the patient's medical history, current medical conditions being treated, list of all medications currently being taken by the patient, explaining why implants are medically necessary and why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition, and certifying that the patient is an appropriate candidate for implant placement. If the patient's dentist indicates that the patient is currently being treated for a serious medical condition, the Department may request further documentation from the patient's treating physician.
>
> **General Guidelines:**
>
> - The dentist's explanation as to why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular teeth.
> - A complete treatment plan addressing all phases of care is required and should include the following:
>   - Accurate pretreatment charting;
>   - Complete treatment plan addressing all areas of pathology;
>   - Inter-arch distances;
>   - Number, type and location of implants to be placed;
>   - Design and type of planned restoration(s);
>   - Sufficient number of current, diagnostic radiographs and/or CT scans allowing for the evaluation of the entire dentition.
> - If bone graft augmentation is needed there must be a 4 to 6-month healing period before a dental implant can be placed.
> - Dental implant code D6010 will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments, crowns, or dentures four to six months after dental implant placement.

- Treatment on an existing implant/implant prosthetic will be evaluated on a case-by-case basis.
- Documentation must include a list of all medications currently being taken and all conditions currently being treated.
- All cases will be considered based upon supporting documentation and current standards of care.

iii. Commentary

- The prior requirement that a member's physician must provide documentation explaining how dental implants would alleviate a member's medical condition has been REMOVED.

- MCOs and Fee-for-Services providers are REQUIRED to submit NYS DOH Prior Authorization Form: Evaluation of the Dental Implant Patient with ALL requests for dental implants.

  Note: MCOs and Fee-for Service providers are directed to complete the entirety of Prior Authorization Form prior to submitting it to NYS DOH.

- The Prior Authorization Form DOES NOT need to be notarized, and MCOs and Fee-for-Service providers cannot impose additional criteria other than what is provided on NYS DOH Prior Authorization Form

- A member's dentist must still explain, with supporting medical documentation, why a dental implant is medically necessary.

  - *Example*: Medical necessity may include, but is not limited to, partial or complete edentulism or traumatic injury to osseous structures of head, jaw and/or face resulting in inadequate remaining osseous support for conventional dental prosthesis. Medical necessity will be evaluated on a case-by-case basis.

- A member's dentist must also still explain why other functional alternatives for prosthetic replacement (such as a partial denture) would not correct the member's dental condition.

  - *Examples:* (1) a member may be unable to operate a removeable prosthesis due to a neurological disorder (i.e., a seizure disorder, Parkinson's disease); (2) a member may lack the bone support necessary to maintain a removable prosthesis.

- Single tooth implants are covered if they meet the other coverage criteria set forth in Section VIII of the Dental Manual.

- The need for a prosthetic replacement (including implants) is based, in part, on the absence of 8 points of posterior contact or missing anterior teeth as described in the General Guidelines. Reviewers must undertake a full medical necessity evaluation, assessing all of the clinical criteria applicable to prosthetic replacements contained in the Dental Manual.

III. QUESTIONS

Questions related to Fee-for-Service should be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473-2160 or dentalpolicy@health.ny.gov.

Questions related to MCOs should be directed to the enrollee's MCO plan.