Updated versions of the New York State (NYS) Medicaid Dental Policy and Procedure Code Manual and the NYS Dental Fee Schedule have been published. These updated guidance documents include the changes outlined below. The revised documents are effective January 1, 2019 and may be found online at https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental_Policy_and_Procedure_Manual.pdf

NYS Dental Policy and Procedure Manual: 1/1/2019 Revisions Table

Page Number	11/12/2018 Manual (previous)	Action	Page Number	1/1/2019 Manual (updated/current)
Pg. 9, 31 (2x), 32, and 77 (2x)	OMRDD	Changed	Pg. 9, 32 (2x), 33, and 78 (2x)	OPWDD
Pg. 7	Please refer to the EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid), available at the following website: https://www.emedny.org/ProviderManuals/index.aspx	Changed	Pg. 7	Please refer to the New York Medicaid Child/Teen Health Program (C/THP) Provider Manual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) available at the following website: https://www.emedny.org/ProviderManuals/index.aspx
Pg. 8	• Except for orthodontic treatment, clinics and schools are exempt from the prior approval procedure because of internal quality assurance processes that insure their compliance with existing Medicaid policy. Prior approval is required for orthodontic services.	Changed	Pg. 8	➢ Except for implants, implant related services and orthodontic treatment, clinics and schools are exempt from the prior approval procedure because of internal quality assurance processes that insure their compliance with existing Medicaid policy.
Pg. 9	➢ When billing • Other than orthodontic services (D8000 – D8999) there is NO FEE-FOR-SERVICE (FFS) BILLING; • Prior approval is required for orthodontic services; • Certify that the services were provided; • For specific instructions, please refer to the Dental Billing Guidelines at: https://www.emedny.org/ProviderManuals/Dental/index.aspx	Changed	Pg. 9	➢ When billing: • Other than orthodontic services (D8000 – D8999) and implant and implant related services (D6010 -D6199) there is **NO FEE-FOR-SERVICE (FFS) BILLING**; • Prior approval is required for orthodontic services and implants and implant related services; • Certify that the services were provided; For specific instructions, please refer to the Dental Billing Guidelines at: https://www.emedny.org/ProviderManuals/Dental/index.aspx

Pg. 10	➢ Periodontal surgery, except for procedure D4210 – gingivectomy or gingivoplasty, for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;	Changed	Pg. 10	➢ 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;
Pg. 15	➢ **Hospital In-Patient; Ambulatory Surgery; Emergency Room** The "professional component" for dental services can be reimbursed on a fee-for-service basis. Payment for those services requiring prior approval / prior authorization is dependent upon obtaining approval from the Department of Health.	Changed	Pg. 15	➢ **Hospital In-Patient; Ambulatory Surgery; Emergency Room** The "professional component" for dental services can be reimbursed on a fee-for-service basis. Payment for those services requiring prior approval / prior authorization is dependent upon obtaining approval from the Department of Health or the Medicaid Managed Care Plan.
Pg. 16	➢ The member must be informed of **alternative treatment plans**, including procedures covered by the Medicaid Program or procedures that require prior authorization by the NYS DOH, the advantages and disadvantages of each, as well as the expense and financial responsibilities of each (If any of the procedures in the treatment plan require prior approval from the Medicaid Program, the provider is encouraged to submit the necessary forms and documentation for review and determination, which may eliminate the need for a private payment agreement and Medicaid could cover the procedure(s) in full);	Changed	Pg. 16	➢ The member must be informed of **alternative treatment plans**, including procedures covered by the Medicaid Program or procedures that require prior authorization by the NYS DOH or Medicaid Managed Care Plan, the advantages and disadvantages of each, as well as the expense and financial responsibilities of each (If any of the procedures in the treatment plan require prior approval from the Medicaid Program, the provider is encouraged to submit the necessary forms and documentation for review and determination, which may eliminate the need for a private payment agreement and Medicaid could cover the procedure(s) in full);
Pg. 17	Claims for fixed and removable prosthetics and endodontics are **not** to be submitted until the treatment is completed.	Changed	Pg. 17	Claims for fixed and removable prosthetics (including implant related prosthetics) and endodontics are **not** to be submitted until the approved procedure code is completed.

<table>
<tr><td>Pg. 18</td><td>When Prior Approval is required
For professional dental services, payment for those listed procedures where the procedure code number is underlined and listed as (PA REQUIRED) is dependent upon obtaining the approval of the Department of Health prior to performance of the procedure.</td><td>Changed</td><td>Pg. 18</td><td>When Prior Approval is required
For professional dental services, payment for those listed procedures where the procedure code number is underlined and listed as (PA REQUIRED) is dependent upon obtaining the approval of the Department of Health or the Medicaid Managed Care Plan prior to performance of the procedure.</td></tr>
<tr><td>Pg. 25</td><td>Managed Care Plans:
All Medicaid Managed Care plans, Essential Plans and Family Health Plus plans offering dental services, must continue to cover any remaining treatments required to complete the procedures listed below if a managed care enrollee is disenrolled from the plan for any reason (including, but not limited to, losing Medicaid eligibility, transferring to another plan or voluntary disenrollment) after a decisive appointment. Such coverage is required even if the member does not qualify for guaranteed eligibility.</td><td>Changed</td><td>Pg. 25</td><td>Managed Care Plans:
All Medicaid Managed Care plans, and Essential Plans offering dental services, must continue to cover any remaining treatments required to complete the procedures listed below if a managed care enrollee is disenrolled from the plan for any reason (including, but not limited to, losing Medicaid eligibility, transferring to another plan or voluntary disenrollment) after a decisive appointment. Such coverage is required even if the member does not qualify for guaranteed eligibility.</td></tr>
<tr><td>Pg. 26</td><td>NA</td><td>Added two (2) rows to Decisive Appointment Table</td><td>Pg. 26</td><td><table>
<tr><td>Implant Services</td><td>D6052-D6067, D6094,D6095, D6110- D6113</td><td>D6199</td><td>Final impression for the specific procedure code</td></tr>
<tr><td>Implant Services</td><td>D6090, D6091</td><td>D6199</td><td>Acceptance of prosthesis for repair</td></tr>
</table></td></tr>
<tr><td>Pg. 30</td><td>Photographs are reimbursable when associated with procedures described under sections:
➢ VIII. IMPLANTS;
➢ XI. ORTHODONTICS; and,
➢ When requested by the Department Health</td><td>Changed</td><td>Pg. 30</td><td>Photographs are reimbursable when associated with procedures described under sections:
➢ VIII. IMPLANTS;
➢ XI. ORTHODONTICS;
➢ When requested by the Department Health; and,
➢ The fee includes all intra-oral and extra-oral images taken on the same date of service.</td></tr>
<tr><td>Pg. 35</td><td>D1515 Space maintainer – fixed – bilateral (ARCH)</td><td>Deleted</td><td>NA</td><td>NA</td></tr>
</table>

NA	NA	Added	Pg. 34	D1516 Space maintainer – fixed – bilateral, maxillary D1517 Space maintainer – fixed – bilateral, mandibular
Pg. 42	D4210 and D4211 are reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects. The provider must submit documentation, including photographs, demonstrating the need for this treatment as an attachment to a paper claim. Photographs taken for this purpose should be billed using D0999.	Changed	Pg. 43	D4210 and D4211 are reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects. The provider must keep in the treatment record detailed documentation describing the need for gingivectomy or gingivoplasty including pretreatment photographs depicting the condition of the tissues.
Pg. 45	D5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	Changed	Pg. 46	D5211 Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)
Pg. 45	D5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	Changed	Pg. 46	D5212 Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)
Pg. 46	D5630 Repair or replace broken clasp -per tooth	Changed	Pg. 47	D5630 Repair or replace broken retentive/clasping materials – per tooth
Pg. 49	• Sufficient number of current, diagnostic radiographs allowing for the evaluation of the entire dentition.	Changed	Pg. 50	• Sufficient number of current, diagnostic radiographs and/or CT scans allowing for the evaluation of the entire dentition.
Pg. 67	When a member undergoing active orthodontic treatment that was authorized by MMC Plan (or their vendor) has coverage changed to fee-for-service Medicaid, a prior approval for continued treatment is required from the fee-for-service program. A prior approval request for continuation of orthodontic care (D8670) should be submitted to eMedNY with the following documentation:	Changed	Pg. 68	When a member undergoing active orthodontic treatment that was authorized by MMC Plan (or their vendor) has coverage changed to fee-for-service Medicaid, a prior approval for continued treatment is required from the fee-for-service program. In such cases, providers **must** adhere to the original treatment time authorized by MMC Plans. A prior approval request for continuation of orthodontic care (D8670) should be submitted to eMedNY with the following documentation:
Pg. 67	Orthodontic coverage for procedure codes D8670 and D8680 is subject to the member's eligibility under the FFS Medicaid Program.	Changed	Pg. 68	Again, orthodontic coverage for procedure codes D8670 and D8680 is subject to the member's eligibility.

NA	NA	Added Statement	Pg. 69	The total fee-for-service reimbursement amount for active treatment will not exceed the maximum fees listed in the Dental Fee Schedule.
Pg. 70	(BR)	Deleted	Pg. 71 & 72	NA
Pg. 76	D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician (REPORT NEEDED) The consulted provider must be enrolled in one of the dental specialty areas recognized by the NYS Medicaid program and the claim must include the NPI of the referring provider. The referring provider cannot be from the same group as the consulting provider. The report should include: • A copy of the written request from the referring provider identifying the issue for which they are seeking advice and counsel; and, • A copy of the written evaluation back to the referring provider with the findings, recommendations, and advice and counsel on how the referring provider should proceed. This should occur prior to the start of any treatment by the specialist. If the consultant provider assumes the management of the member after the consultation, subsequent services rendered by that provider will not be reimbursed as consultation. Referral for diagnostic aids (including radiographic images) does not constitute consultation but is reimbursable at the listed fees for such services. Consultation will not be reimbursed if claimed by the same provider within 180 days of an examination or an	Changed	Pg. 77	D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician The consulted provider must be enrolled in one of the dental specialty areas recognized by the NYS Medicaid Program. The referring provider cannot be from the same group as the consulting provider. If the consultant provider assumes the management of the member after the consultation, subsequent services rendered by that provider will not be reimbursed as consultation. Referral for diagnostic aids (including radiographic images) does not constitute consultation but is reimbursable at the listed fees for such services. Consultation will not be reimbursed if claimed by the same provider within 180 days of an examination or an office visit for observation (D9430). An exception can be made if a subsequent consultation is held for a distinctly different condition, supported by documentation.

	office visit for observation (D9430). An exception can be made if a subsequent consultation is held for a distinctly different condition, supported by documentation.			
Pg. 77	D9920 Behavior Management, by report	Changed	Pg. 78	D9920 Behavior Management
Pg. 78	D9940 Occlusal guard, by report (REPORT NEEDED) (BR)	Deleted	Pg. 79	NA
NA	NA	Added	Pg. 79	For occlusal guards there must be a minimum interval of twelve (12) months between all occlusal guards (D9944, D9945, and/or D9946) and the report must include documentation of necessity, associated laboratory receipts and a copy of treatment progress notes indicating the date of insertion. D9944 **Occlusal guard – hard appliance, full arch** (REPORT NEEDED) $145.00 Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances. D9945 **Occlusal guard – soft appliance, full arch** (REPORT NEEDED) $145.00 Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances. D9946 **Occlusal guard – hard appliance, partial arch** (REPORT NEEDED) $145.00 Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Provides only partial occlusal coverage such as anterior deprogrammer. Not to be reported for any type of sleep apnea, snoring or TMD appliances.
NA	NA	Added, Effective beginning 1/17/2019	Pg. 79	D9990 **Certified translation or sign-language services – per visit** (REPORT NEEDED) $22.00 ***D9990 is a new code; it replaces T1013 beginning on 1/17/2019.** **For dates of service prior to 1/17/2019 use T1013.**

				For patients with limited English proficiency defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with health care providers and their staff. The need for medical language interpreter services must be documented in the medical record and must be provided during a medical visit by a third party interpreter, who is either employed by or contracts with the Medicaid provider. These services may be provided either face-to-face or by telephone. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI). Documentation of necessity must be submitted as an attachment to a paper claim.
Pg. 79	T1013 Sign Language or Oral Interpretive Services (REPORT NEEDED) $11.00 For patients with limited English proficiency defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with health care providers and their staff. The need for medical language interpreter services must be documented in the medical record and must be provided during a medical visit by a third party interpreter, who is either employed by or contracts with the Medicaid provider. These services may be provided either face-to-face or by telephone. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI).	Deleted on 1/17/2019 (Replaced by D9990)	NA	NA

	Reimbursement of medical language interpreter services is payable with HCPCS procedure code T1013- sign language and oral interpretation services and is billable during a medical/dental visit. Limited to two (2) units: One Unit: Includes a minimum of eight (8) and up to 22 minutes; Two Units: Includes 23 or more minutes. Documentation of necessity must be submitted as an attachment to a paper claim.			

- Please contact dentalpolicy@health.ny.gov should you have any questions regarding this document.