Page Number	Version 2022-2 Manual (previous)	Action	Page Number	1/1/23 Manual (updated/current)
		Addition	6	Updated contact: The New York State Office of the Medicaid Inspector General Division of Medicaid Investigations, (518) 408-0664; Additional information on OMIG protocols can be found at: https://omig.ny.gov/audit/audit-protocols
9	Other than orthodontic services (D8000 – D8999) and implant and implant related services (D6010 -D6199) there is NO FEE-FOR-SERVICE (FFS) BILLING;	Clarification	9	Other than orthodontic services (D8000 – D8999) and implant and specified implant related services (D6010 - D6199) there is NO FEE-FOR-SERVICE (FFS) BILLING;
		Addition	12	Claims and prior authorization requests must be complete. All attachments must be labeled with patient and provider identification and date.
		Addition	16	Review general policy "When Medicaid Enrollees Cannot be Billed" at General Policy Information for All Providers.
16	Providers are prohibited from charging any additional amount for a service billed to the Medicaid program.	Addition	16	Providers are mandated to comply and adhere with NYS Medicaid prior approvals and claims submission protocols. Patients cannot be billed and charged due to providers' lack of compliance with these policies. Providers are prohibited from charging any additional amount for a service billed to the Medicaid program.
		Addition	18	The treatment requested must be substantiated by the submitted medical documentation and not primarily for the preference of the client or provider.
		Addition	21	eMedNY Reference and Contact Information Website: www.emedny.org Call Center: 800-343-9000
22	Procedures that do not have a published fee are indicated as "(BR)".	Clarification	22	Procedures that do not have a published fee are indicated as "By Report" (BR).
28	The following ADA / DOHHS recommendations for "prescribing dental radiographs" should be followed: <*inactive link*>	Addition	28	The most current recommendations for prescribing dental radiographs should be followed. Revised guidance from ADA, HHS, and FDA can be found at The Selection of Patients for Dental Radiographic Examinations | FDA.

		Addition	28	Capture and interpretation of intraoral images are not separately reimbursed by this program.
28	D0210 Intraoral - complete series of radiographic images. A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.	CDT Change		D0210 Intraoral - comprehensive series of radiographic images. A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas.
		Addition	36	Caries arresting medicament is not reimbursable when used as a base for a final restoration.
37	D1575 Distal shoe space maintainer – fixed, unilateral – per quadrant (QUAD), Fabrication and delivery of fixed appliance extending subgingivally and distally to guide the eruption of the first permanent molar.	Clarification	37	SPACE MAINTAINERS, D1575 Distal shoe space maintainer – fixed, unilateral – per quadrant (QUAD), Fabrication and delivery of fixed appliance extending subgingivally and distally to guide the eruption of the first permanent molar. Does not include ongoing follow-up or adjustments, or replacement appliances, once the tooth has erupted.
		Addition	38	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. Please review Scope of Program and Non-Reimbursable Services (p10-11) and Essential Services (p 24).
46	Cleaning of removable prosthesis or soft tissue not directly related to natural teeth is not a covered service.	Clarification	47	Cleaning of removable prosthesis or soft tissue not directly related to natural teeth or implants is not a covered service.
		Addition	48	Caries index, periodontal status, and the overall status and prognosis of the entire dentition, as well as recipient compliance, dental history, and medical history, among other factors, will be taken into consideration when determining medical necessity. Please review Scope of

				Program and Non-Reimbursable Services (p10-11) and Essential Services (p 24).
		Addition	73	A HLD index report is not required for procedure codes D8010 and D8020 as they are primarily intended and utilized for interceptive orthodontic treatment.
		Addition	76	<u>CONTINUATION OF ACTIVE ORTHODONTIC TREATMENT FOR CHILDREN WHEN THEIR DOMICILE CHANGES</u> When there is a change in the domicile of a member in mid-treatment, a continuation of active orthodontic treatment may be required with a new orthodontist who participates in the NYS Medicaid Orthodontic program (FFS and MMC plan). It is desirable and recommended to continue and finish the active orthodontic treatment utilizing the existing functional orthodontic appliances. In a situation when the new orthodontist cannot continue the active orthodontic treatment with the existing orthodontic appliances due to multiple missing brackets and/or different treatment plans, then a detailed narrative substantiating the need for new orthodontic appliances must be submitted with a prior approval request. A prior approval request for continuation of orthodontic care (D8670) should be submitted to either eMedNY (for FFS members) or to the member's Medicaid Managed Care Plan (or their vendors) with the following documentation: • Current orthodontic records depicting the current dentition, and treatment plan indicating the anticipated length of active orthodontic treatment • AAO (American Association of Orthodontists) Transfer Form.
81	D9110 Palliative (emergency) treatment of dental pain - minor procedure (REPORT	CDT Change	84	D9110 Palliative treatment of dental pain-per visit (REPORT NEEDED) Treatment that relieves pain but is not curative;

	NEEDED) Not reimbursable in addition to other therapeutic services performed at the same visit or in conjunction with initial or periodic oral examinations when the procedure does not add significantly to the length of time and effort of the treatment provided during that particular visit. When billing, the provider must document the nature of the emergency, the dental site and the specific treatment involved. Not to be used for denture adjustments (Refer to procedure codes D5410 – D5422).			services provided do not have distinct procedure codes. Not reimbursable in addition to other therapeutic services performed at the same visit or in conjunction with initial or periodic oral examinations when the procedure does not add significantly to the length of time and effort of the treatment provided during that particular visit. When billing, the provider must document the nature of the emergency, the dental site and the specific treatment involved. Not to be used for denture adjustments (Refer to procedure codes D5410 – D5422).
82	D9420 Hospital or ambulatory surgical center call (REPORT NEEDED) Per visit, per member (to be added to fee for service). This service will be recognized only for professional visits for pre-operative or operative care. Post-operative visits are not reimbursable when related to procedures with assigned follow-up days. Hospital calls are not reimbursable for hospital-based providers. Payable only when provided in a FACILITY where professional services are not included in the rate. Please submit documentation that services were provided in a hospital, such as a copy of the hospital notes/record.	Change	85	D9420 Hospital or ambulatory surgical center call (REPORT NEEDED)Per visit, per member (to be added to fee for service). This service will be recognized only for professional visits delivered in hospital in-patient, Emergency Department, and ambulatory surgical settings. Payable only when provided in a FACILITY where professional services are not included in the rate. Please submit documentation that services were provided in a hospital, such as a copy of the hospital notes/record.
		Addition	86	D9612 Therapeutic parenteral drugs, two or more administrations, different medications (By Report)
84	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	Addition	87	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 medical necessity, associated laboratory

	documentation of necessity, associated laboratory receipts and a copy of treatment progress notes indicating the date of insertion.			receipts and a copy of treatment progress notes indicating the type of guard and date of insertion. Treatment notes must include documentation of symptoms and/or clinical findings supporting guard fabrication.
84	D9990 Certified translation or sign-language services – per visit, 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.	Clarification	87	D9990 Certified translation or sign-language services – per visit, For patients who are deaf and hard of hearing or 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.
85	Telehealth services must be delivered by dentists acting within their scope of practice.	Addition	88	Telehealth services must be delivered by dentists acting within their scope of practice. Dental telehealth services shall adhere to the standards of appropriate patient care required in other dental health care settings. All dental telehealth providers shall identify themselves to patients, including providing the professional's New York state license number. Please refer to Legislation addressing Telehealth Delivery of Services, available at Legislation | NY State Senate (nysenate.gov) .
86	Telephone conversations, e-mail or text messages, and facsimile transmissions between a dentist and a Medicaid member or between two dentists are not considered telehealth services and are not covered by Medicaid when provided as standalone services. Remote consultations between practitioners, without a Medicaid member present, including for the purposes of teaching or skill building, are not	Deletion	89	

	considered telehealth and are not reimbursable.			
87	Accompanying payable services will be reimbursed at 75% of the requested fee, not exceeding 75% of the current Medicaid fee.	Deletion	90	
87	Q3014 Telehealth originating site facility fee. Procedure code Q3014 may be used by the provider at the originating site; Must be reported on claim line #1; Report all services rendered on subsequent lines.	Clarification	90	Q3014 Telehealth originating site facility fee. Procedure code Q3014 may be used by the provider at the originating site; Must be reported on claim line #1; Report any additional services rendered on subsequent lines.
88	D9997 Dental Case management – patients with special health care needs. Special treatment considerations for patients/individuals with physical, medical, developmental, or cognitive conditions resulting in substantial functional limitations or incapacitation, which require that modifications be made to delivery of treatment to provide customized comprehensive oral health care services. This code is replacing D9920 as of 01/01/2021. When billing, please use the procedure code that was active on the date the service was rendered. Code D9920 is valid if performed prior to 01/01/2021. • This is a per visit incentive to compensate for the greater knowledge, skill, sophisticated equipment, extra time and personnel required to treat this population;	Clarification	91	D9997 Dental Case management – patients with special health care needs. Special treatment considerations for patients/individuals with physical, medical, developmental, or cognitive conditions resulting in substantial functional limitations or incapacitation, which require that modifications be made to delivery of treatment to provide customized comprehensive oral health care services. • For purposes of the NYS Medicaid program, billing of this code is limited to individuals who receive ongoing services from community programs operated or certified by the New York State Office for People with Developmental Disabilities (OPWDD) with a recipient exception code of RE 81 (“TBI Eligible”) or RE 95 (“OPWDD/Managed Care Exemption”). • This is a per visit incentive to compensate for the greater knowledge, skill, sophisticated equipment, extra time and personnel required to treat this population; • This fee will be paid in addition to the normal fees for specific dental procedures.

	• This fee will be paid in addition to the normal fees for specific dental procedures. • For purposes of the NYS Medicaid program, the developmentally disabled population (OPWDD members) for which procedure code D9997 may be billed is limited to those who receive ongoing services from community programs operated or certified by the New York State Office for People with Developmental Disabilities (OPWDD). These individuals are identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OPWDD/Managed Care Exemption"). • A "Medical Immobilization/Protective Stabilization (MIPS)" form (Institutions only) also qualifies for use of this procedure code. • Not billable in conjunction with D9430 or procedures performed under deep sedation/general anesthesia. • Not billable as a "stand-alone" procedure; another clinical service must be provided on the same date. Does not require a report.			• A "Medical Immobilization/Protective Stabilization (MIPS)" form (Article 16 institutions only) also qualifies for use of this procedure code. More information about MIPS found online at NYS Office for People With Developmental Disabilities at NYS MIPS. • Not billable in conjunction with D9430 or procedures performed under deep sedation/general anesthesia. • Not billable as a "stand-alone" procedure; another clinical service must be provided on the same date. Does not require a report.
		Addition	92-93	Appendix highlighting services available to the Intellectual and Developmental Disabilities (IDD) population

				(with Recipient Exception codes RE 81/RE 95 OPWDD/Managed Care Exemption)

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 above. The revised documents are effective January 1, 2023 and may be found online at https://www.emedny.org/ProviderManuals/Dental/PDFS/Dental_Policy_and_Procedure_Manual.pdf

Please contact dentalpolicy@health.ny.gov with questions.