NYS Dental Policy and Procedure Manual: 1/31/2024 REVISIONS TABLE

Page Number	Version 2023	Action	Page Number	Version 2024
6		New contact information	4	Division of Medicaid Investigations 1-877-873-7283
8	Place of Service Code Set - Centers for Medicare & Medicaid Services	New Link for **Place of Service Code Set**	6	Please refer to the Centers for Medicare and Medicaid Services website (CMS.gov) for additional information: Place of Service Code Set | CMS
9	• Other than orthodontic services (D8000 – D8999) and implant and specified implant related services (D6010 -D6199) there is NO FEE-FOR-SERVICE (FFS) BILLING; • For specific instructions, please refer to the Dental Billing Guidelines at: https://www.emedny.org/ProviderManuals/Dental/index.aspx	Reworded/ clarified clinic billing guidance	6	• Clinics billing using Ambulatory Payment Group methodology should submit a FEE-FOR-SERVICE (FFS) claim only when billing for orthodontic services (D8000 – D8999) and implant and specified implant-related services (D6010-D6199). • Practitioners can submit a professional claim in the inpatient, Emergency Department, and Ambulatory Surgery settings. • For specific instructions, please refer to the Dental Billing Guidelines at: https://www.emedny.org/ProviderManuals/Dental/index.aspx or contact eMedNY - (800) 343-9000.
10	• Molar root canal therapy for members 21 years of age and over, except when extraction would be medically contraindicated or the tooth is a critical abutment for an existing serviceable prosthesis • Replacement of partial or full dentures prior to required time periods unless appropriately documented and justified as stated in the Manual;	Deleted, under **Services Not Within the Scope of the Medicaid Program**	7	
10		Added, under **Services Not Within the Scope of the Medicaid Program**	7	• Crown lengthening, except when associated with medically necessary crown or endodontic treatment.
11	Services associated with a non-approved procedure will not be considered for reimbursement.	New language	8	Services associated with a non-approved procedure may not be considered for reimbursement.
12		Added, under **The patient's Dental Record is to include**	8	• Justification of Need for Replacement Prosthesis Form and Evaluation of the Dental Implant Patient Form (if used).
12	Detailed description of all services rendered including the identification of the healthcare professional providing the service(s);	Added, under **Treatment notes are to include the following for each**	8	• Accurate and detailed description of all services rendered including the identification of the healthcare professional providing the service(s); • Documentation of diagnosis/reason for procedure; • Documentation of the materials used;

		dental appointment		
14		Added	10	Treatment submitted on claims must be supported in the patient record by documentation of medical need.
14		Added	10	At the time of this publication, School Based Health Center services are carved out of Managed Care and should be billed as Fee-for-Service.
15		Added	11	Ambulatory Surgical Centers submitting an Ambulatory Patient Group (APG) claim to NYS Medicaid should indicate the number of units on the claim line for CPT code "**41899**" based on the duration of the encounter, up to a maximum of four units for those individuals identified with a recipient exception code of "RE 81" ("TBI Eligible") or "RE 95" (OPWDD/Managed Care Exemption"), using guidance provided in the July 2023 Medicaid Update, found at New York State Medicaid Update - July 2023 Volume 39 - Number 12 (ny.gov).
16		Added, under **Payment in Full**	11	Additional guidance can be found at https://www.health.ny.gov/health_care/medicaid/program/update/2014/2014-02.htm#bill
17		Added, under **Third-Party Insurers**	12	Under the Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS) issued new regulations for payment for dental services that are **inextricably linked** to certain covered medical services, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, valvuloplasty procedures, and treatment for head and neck cancers. For more information, visit the CMS website Medicare Dental Coverage | CMS
		Added, **Prior Authorization Checklist**	13	
		Added Definition	16	Medically Necessary 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).)
21	e MedNY Reference and Contact Information Website: www.emedny.org Call Center: 800-343-9000	Added Contacts	17	• General questions related to the New York State Medicaid Fee-for-Service Dental Program should be directed to the Office of Health Insurance Programs, Division of Program

				Development and Management at (518) 473-2160 or dentalpolicy@health.ny.gov. • Providers are encouraged to enroll in ePACES and subsequently submit their prior approval requests and claims electronically. Prior approval status and claims inquiry can be checked online via ePACES. Providers who are not enrolled in ePACES can call the **eMedNY Call Center at 1-800-343-9000** with questions regarding prior approvals and claims. eMedNY customer service representatives will refer appropriate calls to the Bureau of Dental Review (1-800-342-3005, option #2) if further assistance is required. • Questions related to New York State Medicaid Managed Care should be directed to the enrollee's Managed Care Plan.
22		Added, under **"(REPORT NEEDED)" / "BY REPORT (BR)" PROCEDURES**	17	Claims submitted without any report/documentation will be denied.
22		Clarified language under **"(REPORT NEEDED)" / "BY REPORT (BR)" PROCEDURES**	17	To ensure appropriate payment in the context of current Medicaid fees, the usual and customary fee charged to the general public should be billed.
24	Treatment will not be routinely approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible. 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. Treatment is not considered appropriate when the prognosis of the tooth is questionable or when a reasonable alternative course of treatment would be extraction of the tooth and replacement. Treatment such as endodontics or crowns will not be approved in association with an existing or proposed prosthesis in the same arch, unless the tooth is a critical abutment for a prosthesis provided through the NYS Medicaid program, or unless replacement by addition to an existing prosthesis or new prosthesis is not feasible. If the total number of teeth which require or are likely to require treatment would be considered excessive or when maintenance of	New language, under "**ESSENTIAL SERVICES**"	18	• 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 when 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. • 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, refer to the following specific sections of the Manual: o Crowns (located in Section III); o Endodontics (Section IV);

	the tooth is not considered essential or appropriate in view of the overall dental status of the recipient, treatment will not be covered. Eight (8) posterior natural or prosthetic teeth (molars and/or bicuspids) in occlusion (four (4) maxillary and four (4) mandibular teeth in functional contact with each other) will be considered adequate for functional purposes. Requests will be reviewed for necessity based upon the presence/absence of eight (8) points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact). One (1) missing maxillary anterior tooth or two (2) missing mandibular anterior teeth may be considered an esthetic problem that warrants a prosthetic replacement			○ Prosthodontics (Section VI); and ○ Implant Services (Section VIII)
28		Added language	21	For purposes of the NYS Medicaid program, an intraoral, comprehensive series (full mouth) consists of at least ten (10) periapical films plus bitewings.
32	The additional prophylaxis should be submitted using procedure code D1999.	Code change	24	The additional prophylaxis should be submitted using the appropriate procedure code (D1110 or D1120).
32		Added language	25	Note: FQHCs who opt out of Ambulatory Patient Groups (APG) cannot bill a separate threshold rate for Topical Fluoride Application (D1206, D1208) as a standalone procedure at a patient encounter where no other reimbursable services are delivered.
32	D1206 Topical application of fluoride varnish $30.30 Reimbursable once per three (3) month period for members between 6 months and 20 years of age (inclusive).	Clarification	25	D1206 Topical application of fluoride varnish $30.30 Reimbursable once per three (3) month period for members, from eruption of first tooth through age 20 (inclusive).
38	The cost of analgesic and anesthetic agents is included in the reimbursement for the dental service. The administration of nitrous oxide is not separately reimbursable.	New policy	28	Unless otherwise specified, the cost of analgesic and anesthetic agents is included in the reimbursement for the dental service.
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).	New language	28	**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. **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. Please review

				Scope of Program and Non-Reimbursable Services (p 7) and Essential Services (p 18).
38	If a non-covered surgical procedure (e.g. crown lengthening, D4249) is required to properly restore a tooth, any associated restorative or endodontic treatment will NOT be considered for reimbursement.	New language	28	If a non-covered surgical procedure is required to properly restore a tooth, any associated restorative or endodontic treatment will NOT be considered for reimbursement. Note, this provision does not apply to crown lengthening, which will be considered for reimbursement when associated with any medically necessary crown or endodontic treatment.
40	Crowns will not be routinely approved for a molar tooth in those members age 21 and over which has been endodontically treated without prior approval from the Department of Health.	New language, under **CROWNS – Single Restorations Only**	29	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 and over** will be covered when medically necessary. In determining whether a requested crown is medically necessary, the following factors may be considered: • There is a documented medical condition which precludes an 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: o The periodontal status, member compliance and overall status and prognosis of the tooth is favorable o The tooth is not routinely restorable with a filling o There are eight or more natural or prosthetic posterior points of contact present o If the posterior tooth is a molar, treatment of the molar is necessary to maintain functional or balanced occlusion of the patient's dentition o Consideration for a third molar will be given if the third molar occupies the first or second molar position o **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
42	Molar endodontic treatment, retreatment or apical surgery is not approvable as a routine procedure. Prior approval requests will be will only be considered for members under age 21 who display good oral hygiene, have healthy mouths with a full complement of natural teeth with a low caries index and/or who may be undergoing orthodontic treatment. In those members age 21 and over, molar endodontic therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis and when the tooth cannot be extracted and replaced with a new prosthesis, or; where there is a documented medical condition which precludes extraction	New language, under **ENDODONTICS**	31	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 an 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 ○ There are eight 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 molar occupies the first or second 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.

45	For details regarding the "PERIODONTICS" codes that are associated with the implant and implant related services benefit ONLY (D4245, D4266, D4267, D4273, D4275, D4277, D4278, D4283, D4285), see section VIII. IMPLANTS.	Added new codes	33	For details regarding the "PERIODONTICS" codes that are associated with the implant and implant related services benefit ONLY (D4245, D4266, D4267, D4273, D4275, D4277, D4278, D4283, D4285, D6106, D6107), see section VIII. IMPLANTS.
		Addition	33	D4249 Clinical Crown Lengthening – hard tissue (PA REQUIRED) Crown lengthening requires reflection of a full thickness flap and removal of bone, altering the crown to root ratio. The periodontal status, member compliance, and overall status and prognosis of the tooth may be taken into consideration when determining medical necessity. Crown lengthening is reimbursable solely when associated with medically necessary crown or root canal procedure. All requests for coverage of a crown lengthening should include a complete treatment plan addressing all areas of pathology. The provider must keep in the treatment record detailed documentation describing the need for crown lengthening including pretreatment photographs depicting the condition of the tissues. 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 Prior Approval Change Request information on page 14.
47	Full and /or partial dentures are covered by Medicaid when they are required to alleviate a serious health condition or one that affects 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 years from initial placement except when determined medically necessary by the Department or its agent. Prior approval requests for replacement dentures prior to eight years must include a letter from the patient's physician and dentist. A letter from the patient's dentist must explain the specific circumstances that necessitates replacement of the denture. The letter from the physician must explain how dentures would alleviate the patient's serious health condition or improve employability. If replacement dentures are requested within the eight-year period after they have	New language, under **Prosthodontics (Removable)**	35	Full and /or partial dentures are covered by Medicaid when they are determined to be medically necessary, including when necessary to alleviate a serious health 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 years from initial placement except when determined medically necessary by the Department or its agent. Prior approval requests for replacement dentures prior to eight years must include a completed **Justification of Need for Replacement Prosthesis 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-year period after they have already been replaced once, then the dentist's supporting documentation must include an explanation of

	already been replaced once, then supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.			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 anterior teeth.
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).	New language, under **Partial Dentures (Including routine post-delivery care)**	36	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 (p 7) and Essential Services (p 18).
53	Dental 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 physician and dentist. A letter from the patient's physician must explain how implants will alleviate the patient's medical condition. A letter from the patient's dentist must explain why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition and why the patient requires implants. General Guidelines:	New language, under **VIII. IMPLANT SERVICES D6000-D6199**	39	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 **Evaluation of the Dental Implant Patient 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 anterior teeth.

57	The following procedure codes are a covered benefit only when associated with an implant or an implant-related service: D4245, **D4266, D4267**, D4273, D4275, D4277, D4278, D4283, D4285.	Code Update	42	The following procedure codes are a covered benefit only when associated with an implant or an implant-related service: D4245, **D6106, D6107**, D4273, D4275, D4277, D4278, D4283, D4285.
	D4266 Guided tissue regeneration, natural teeth – resorbable barrier, per site (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal and peri-implant defects. **D4267** Guided tissue regeneration, natural teeth – non-resorbable barrier, per site (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal and peri- implant defects.	Code Update/New Codes	42	**D6106** Guided tissue regeneration – resorbable barrier, per implant (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) This procedure does not include flap entry and closure, or, when indicated, would debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for per-implant defects and during implant placement. **D6107** Guided tissue regeneration – non-resorbable barrier, per implant (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) This procedure does not include flap entry and closure, or, when indicated, would debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for per-implant defects and during implant placement **D4266** Guided tissue regeneration, natural teeth – resorbable barrier, per site (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth. **D4267** Guided tissue regeneration, natural teeth – non-resorbable barrier, per site (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth.
66	D7520 Incision and drainage of abscess – extraoral soft tissue (QUAD) (POST OPERATIVE CARE: 21 DAYS)	Addition, “By Report”	50	D7520 Incision and drainage of abscess – extraoral soft tissue (QUAD) (POST OPERATIVE CARE: 21 DAYS) (REPORT NEEDED)

84	The cost of analgesic and anesthetic agents is included in the reimbursement for the dental service.	Policy update	61	Unless otherwise specified, the cost of analgesic and anesthetic agents is included in the reimbursement for the dental service.
		Addition, under **Anesthesia**	61	Appropriate SED certificate is REQUIRED.
84	Anesthesia time is divided into 15 minute units for billing purposes; the number of such units should be entered in the "Times Performed" field of the claim form using the appropriate code (D9223, D9243).	Clarification	61	Anesthesia time is divided into 15-minute units for deep sedation/general anesthesia and intravenous sedation/analgesia for billing purposes; the number of such units should be entered in the "Times Performed" field of the claim form using the appropriate code (D9223, D9243).
		Addition, new policies	62	D9230 Inhalation of Nitrous Oxide/Analgesia, Anxiolysis D9248 Non-Intravenous Conscious Sedation This includes non-IV minimal and moderate sedation. A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non- intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration
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 receipts and a copy of treatment progress notes indicating the type of guard and date of insertion.	Clarification	63	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 receipts (unless fabricated in-house), and a copy of treatment progress notes indicating the type of guard and date of insertion.
		Addition	64	Teledentistry allows dentists and dental hygienists to deliver care from a distance; this includes performing evaluations and delivering services within scope of practice, using either synchronous or asynchronous means.
88	Distant Site is defined as "a site at which a telehealth provider is located while delivering health care services by means of telehealth." Originating and Distant sites must be located within the fifty United States or United States' territories and may include: o Facilities licensed under Article 28 of the Public Health Law (PHL): hospitals, nursing homes and diagnostic and treatment centers;	Clarification	64	Distant Site is defined as "a site at which a telehealth provider is located while delivering health care services by means of telehealth." Most health care facilities and health care settings can be originating sites, as well as a Medicaid Member's place of residence in NYS or temporary location out of state. A full list of allowable originating sites is found in New York Public Health Law § 2999-CC.

	o Facilities licensed under Article 40 of the PHL: hospice programs; o Facilities as defined in subdivision 6 of Section 1.03 of the Mental Hygiene Law (MHL): clinics certified under Articles 16, 31 and 32; o Certified and non-certified day and residential programs funded or operated by the Office of People with Developmental Disabilities (OPWDD); o Private physician or dentist offices located within the State of New York; o Adult care facilities licensed under Title 2 of Article 7 of the Social Security Law (SSL); o Public, private and charter elementary and secondary schools located within the State of New York; o School-age child care programs located within the State of New York; o Child daycare centers located within the State of New York; and, o The member's place of residence in New York State, or other temporary location in or out of state.			
88	Telehealth services must be delivered by dentists acting within their scope of practice.	Clarification	64	Telehealth services must be delivered by providers acting within their scope of practice.
		Addition, under **Telehealth/Teledentistry**	65	Dental telehealth services shall adhere to the standards of appropriate patient care required in other dental health care settings, including but not limited to appropriate patient examination and review of the medical and dental history of the patient. For additional information, providers can refer to NYS Law Chapter 45 Article 29-G §2999-DD, located at NYS Open Legislation | NYSenate.gov. .
92		Clarification	67	Patient records must include documented medical necessity for these benefits.
92	D1999	Code change, **under Appendix: Intellectual and Developmental Disabilities (IDD) population**	67	D1110 or D1120

		New language	68	•Private practitioners receive an enhanced reimbursement rate of 20% over fee schedule for all dental services provided to this population. •Reminder: An additional 20% enhancement is added to the APG base rate for services provided to individuals with a Restriction Exception code of RE 81 (“TBI Eligible”) or RE 95 (“OPWDD/Managed Care Exemption”) for facilities billing through APG methodology using rate codes: 1501, 1489, 1435, and 1425.