NEW YORK STATE
MEDICAID PROGRAM

DENTAL MANUAL

POLICY GUIDELINES

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Section I - Requirements for Participation in Medicaid

Dentists must be licensed and currently registered by the New York State Education Department (NYSED), or, if in practice in another state, by the appropriate agency of that state, and must be enrolled as providers in the New York State Medicaid Program.

No dentist who has been suspended or disqualified from the Medicaid Program may receive reimbursement by the Medicaid Program, either directly or indirectly, while such sanctions are in effect.

Qualifications of Specialists

A specialist is one who:

- Is a diplomate of the appropriate American Board; or
- Is listed as a specialist in the section on character of practice in the American Dental Association's American Dental Directory; or
- Is listed as a specialist on the roster of approved dental specialists of the New York State Department of Health (DOH).

All dentists enrolled in the Medicaid Program are eligible for reimbursement for all types of services except for orthodontic care, examination by an oral surgeon, or dental anesthesiologist, general anesthesia, and parenteral conscious sedation. *There is no differential in levels of reimbursement between general practitioners and specialists*.

Orthodontic care is reimbursable only when provided by an orthodontist or an Article 28 facility which has met the qualifications of the DOH.

General anesthesia and parenteral conscious sedation are reimbursable only when provided by a qualified dentist who is certified in dental anesthesia by the NYSED.

Examination by an oral surgeon or dental anesthesiologist is reimbursable only when provided by a qualified individual as defined above.

Group Providers

A group of practitioners is defined in 18 NYCRR 502.2 as "…two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment)."

Regardless of the arrangement among practitioners (associates, employer-employee, principal-independent contractor), practitioners who practice in a group setting are

required to enroll as a group and to comply with the requirements associated with group practices.

Application of Free Choice

A Medicaid patient is guaranteed free choice of a dental provider in obtaining the dental care available under the New York State Medicaid program.

Credential Verification Reviews

Credential Verification Reviews (CVRs) are periodic onsite visits of a provider's place of business to ensure overall compliance with Medicaid regulations. These visits are conducted by the Medicaid Program, and assess such areas as:

- provider and staff identification and credentialing
- physical attributes of the place of business
- recordkeeping protocols and procedures regarding Medicaid claiming.

CVRs are conducted for such sites as:

- physician and dental offices
- pharmacies
- durable medical equipment retailers, and
- part time clinics.

We do not perform CVRs at hospitals, nursing homes, etc.

Every effort is made to conduct these visits in a professional and non-obtrusive manner. Investigators conducting these reviews will have a letter of introduction signed by the Regional Director for the Bureau of Investigations and Enforcement and a photo identification card.

Should providers, or their staff, have questions regarding these reviews, they can contact:

for Rockland, Westchester, Nassau, Suffolk Counties and New York City

Regional Director
Bureau of Investigations and Enforcement
Metropolitan Area Regional Office
(212) 383-4681

for all upstate counties

Upstate Regional Director
(518) 474-4911.

Section II - Dental Services

Dental Care in the Medicaid Program shall include only **essential services** rather than comprehensive care. The provider should use this Manual to determine when the Medicaid program considers dental services "essential". The application of standards related to individual services is made by the DOH when reviewing individual cases.

Dental clinics licensed under Article 28 and dental schools must follow the policies stated in this Manual and should use this Manual to determine when dental services are considered "essential" by the Medicaid program.

> *These clinics and schools are exempt from the prior approval procedure (except for orthodontia) because of internal quality assurance processes that insure their compliance with existing Medicaid policy*.

Standards of Quality

Services provided must conform to acceptable standards of professional practice.

Quality of Services Provided
Dental care provided under the Medicaid program must meet as high standards of quality as can reasonably be provided to the community-at-large. All materials and therapeutic agents used or prescribed must meet the minimum specifications of the American Dental Association, and must be acceptable to the State Commissioner of Health. Experimental procedures are not reimbursable in the Medicaid program.

Scope of Hospitalization Services

Medicaid recipients are provided a full range of necessary diagnostic, palliative and therapeutic inpatient hospital care, including but not limited to dental, surgical, medical, nursing, radiological, laboratory and rehabilitative services.

Limitations of Hospitalization
Medicaid utilization review (UR) agents are authorized to review the necessity and appropriateness of hospital admissions and lengths of stay, and to determine Medicaid benefit coverage. These review agents will be reviewing inpatient dental services both on a pre-admission and retrospective basis. Emergency admissions may be reviewed retrospectively for necessity and appropriateness.

If you have any questions regarding specific Medicaid hospital review requirements, you may contact the DOH, Bureau of Hospital and Primary Care Services at:

(518) 402-3267.

Child/Teen Health Program

Please refer to the EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid), available at the following website:

http://www.emedny.org/ProviderManuals/index.html

Child Health Plus Program

The goal of the Child Health Plus Program is to improve child health by increasing access to primary and preventive health care through a subsidized insurance program. A child eligible for Medicaid is not eligible for Child Health Plus.

For more information on benefits, contact the Child Health Plus Program at:

(800) 698-4543.

Dental Mobile Van

The use of mobile vans to provide the operatories for the provision of dental services has become more prevalent than in the past.

In recognition of this trend, additional information about the use of such vans or other movable vehicles is requested of dentists seeking to enroll into the Medicaid program for the first time.

As an enrolled dental provider, if you have obtained a van (or other movable vehicle), for the provision of dental services subsequent to your enrollment, you must update your enrollment information. Provider Maintenance Forms are available online at:

http://www.emedny.org/info/ProviderEnrollment/index.html

and must be sent to:

Computer Sciences Corporation
P.O. Box 4610
Rensselaer, New York 12144

Requirements and Expectations of Dental Clinics

General Expectations

- Dental clinics reimbursed on a rate basis (i.e., hospital outpatient departments, diagnostic and treatment centers, and dental schools) are required to follow the policies stated in the Dental Provider Manual.

- The provision of dental care and services are limited in those procedures presented in the Dental Fee Schedule, and are to be provided within the standards and criteria listed in the procedure code descriptions.

- Dental care provided under the Medicaid Program includes only *essential services* (rather than "comprehensive" services).

- When billing:

  - Certifying that the services were provided;

  - Entering the group Medicaid ID number in the Medicaid Group Identification Number field;

  - Entering the Medicaid ID number of the practitioner who actually provided the service in the "Provider Identification Number" field; and

  - Where services are provided at multiple locations, identifying the place of **actual service** on the claim form.

Services Not Within the Scope of the Medicaid Program

- Dental implants;

- Aesthetic veneers, such as porcelain fused to metal crowns (for other than anterior teeth and maxillary first bicuspids);

- Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated;

- Immediate full or partial dentures;

- Molar root canal therapy for patients 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;

- Crown lengthening;

- Replacement of dentures prior to required time periods (currently 4 years), unless appropriately documented and justified as stated in the Manual;

- Dental work for cosmetic reasons or because of the personal preference of the patient;

- 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;

- Adult orthodontics, except in conjunction with, or as a result of, orthognathic surgery;

- Placement of sealants for patients over 15 years old;

- Improper usage of panoramic X-rays (00330) along with intraoral complete series X-rays (00210).

Services Which Do Not Meet Existing Standards of Professional Practice

- Partial dentures provided prior to completion of Phase I restorative treatment which includes removal of all decay and subsequent fillings;

- Extraction of clinically sound teeth for the purpose of placing a partial denture;

- Infected teeth left untreated;

- Restorative fillings redone over a short time period without clinical indication;

- Restorative treatment of teeth that have a hopeless prognosis and should be extracted;

- “Unbundling” of procedures.

Miscellaneous Issues

- Patient medical histories should be updated periodically (annually at a minimum) and be maintained as part of the patient’s dental records. The treating practitioner should refer to the patient history to avoid unnecessary repetition of services.

- Non-emergency initial visits should include a cleaning, X-rays (if required), and a dental exam with a definitive treatment plan. Generally, this should be accomplished in one visit. However, in rare instances, a second visit may be needed for completion of these services. A notation in the record to indicate the necessity for a second visit should be made.

- Quadrant dentistry should be practiced, wherever practicable, and the treatment plan followed in normal sequence.

- Procedures normally requiring multiple visits (i.e., full dentures, partial dentures, root canals, etc.) should be completed in a number of visits that would be considered consistent with the dental community at large. If additional visits are required, a notation in the patient record to indicate the necessity for each additional visit should be made.

- Dental X-rays should be clear and allow for diagnostic assessment. They are performed based on need, age, prior dental history and clinical findings.

- Facilities should use the Department's PVR 292 list (providers who may not bill or order services) when checking and verifying the credentials of the dental professionals that make up their staff.

  This list is currently available on the Department's website at:

  http://www.health.state.ny.us/health_care/medicaid/fraud/dqprvpg.htm

Section III - Basis of Payment for Services Provided

Payment for dental services is limited to the lower of the usual and customary fee charged to the general public or the fee developed by the DOH and approved by the New York State Director of the Budget.

Payment for Services Not Listed on the Dental Fee Schedule

If an "essential" service is rendered that is not listed in the fee schedule, the fee will be determined by the DOH, which will use the most closely related service or procedure in the fee schedule as a base.

Payment for Orthodontic Care

Orthodontic care for severely handicapping malocclusions will be reimbursed for an eligible recipient for a maximum of three years of active orthodontic care, plus one year of retention care.

Cleft palate or approved orthognathic surgical cases may be approved for additional treatment time.

Dental Services Included in a Facility Rate

In State
Dental services are included in certain facility rates. Payment for services to residents of such facilities will not be made on a fee-for-service basis. Dental providers should seek reimbursement for services provided to Medicaid-eligible residents of all New York State Residential Health Care Facilities (RHCF) and some Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) directly from such facilities. It is the responsibility of the ICF-DD to inform the provider if dental services are included in the rate.

Out of State
It is the responsibility of the out-of-state RHCF or ICF-DD to inform the provider if dental services are included in the rate.

Payment in Full

Fees paid by the Medicaid Program shall be considered full payment for services rendered. No additional charge may be made by a provider.

Limitations of Payment

Payment on a fee-for-service basis may not be made to a dentist salaried by a hospital, residential health care facility, or treatment and diagnostic center (free standing clinic)

for services performed in that facility when any portion of the salary is for direct care of patients and there is any prohibition against fee-for-service reimbursement in law, in the rules of the particular facility, or in the contractual agreement with the salaried dentist or dental group.

Medicare and Other Third-Party Insurers

Medicare and other third-party insurers provide reimbursement for various dental procedures. Since Medicaid is the payer of last resort, the dentist must bill the Recipient's third-party payers prior to requesting payment from Medicaid.

Medicaid will reimburse the **difference** only if the third party payment(s) is (are) less than the maximum Medicaid reimbursement for that specific procedure code.

Unspecified Procedure Codes

Unspecified procedure codes at the end of each section of the fee schedule are miscellaneous codes applicable to procedures within the scope of the Medicaid program, but for which suitable procedure codes do not currently exist.

Prior Approval Requirements

Procedures that require prior approval must not begin until the dentist has received approval from the DOH. When any portion of a treatment plan requires prior approval, a **complete** treatment plan listing all necessary procedures must be listed and coded on the prior approval request form. No treatment other than provision of symptomatic relief of pain/infection is to be instituted until such time as cases have been reviewed and a prior approval determination made.

Multiple restorations which are placed in teeth which are subsequently determined to need extraction as part of an approved prosthetic treatment plan are not acceptable if they were provided less than six months prior to the date of the prosthetic prior approval request.

When a treatment plan has been denied, services that were a portion of that plan will not be subsequently approved.

When Prior Approval is Required

Dental procedures that require prior approval are identified in the Procedure Code section of this Manual. All underlined procedure codes require prior approval. Prior Approval must be obtained from the DOH. When procedures are to be performed on an inpatient basis, the protocol established by the hospital for utilization review must be followed.

Emergency Prior Approval

Surgical Services
Emergency treatment is defined as care for severe, life-threatening or potentially disabling conditions that require immediate surgical intervention and a surgical procedure requiring prior approval is most appropriate. Upon completion of the procedure, it will be necessary to submit a written prior approval request to the DOH along with a description of the procedures performed and an explanation of the nature of the emergency. Without this approval the claim cannot be paid.

Non-Surgical Services
When a non-surgical procedure appears to be the definitive treatment of choice, palliative treatment should be initiated to alleviate the emergency condition until prior approval is received for the definitive treatment.

Recipient Restriction Program

Recipients who have been assigned to a designated dentist are required to receive all dental care from the selected provider as a condition of the recipient restriction program (RRP). All claims from other dentists will be denied except under the following circumstances:

- In cases where the primary dentist has referred a recipient to another dentist and the referring provider ID number field of the claim form is appropriately completed; and

- In cases where the service is provided in an inpatient setting.

RRP: Ordered Services
Restricted recipients may only receive certain ancillary services if they are ordered/prescribed by their primary provider. Primary dentists must order/prescribe the following ancillary services related to dental care for recipients restricted to their practice: laboratory, durable medical equipment and pharmacy. The only exception to this policy is when a primary dentist refers a restricted recipient to another dental provider for service. The provider to whom the recipient was referred may also order ancillary services; however, the servicing dental provider must enter the EMEDNY provider number of the patient's primary dentist on all order/prescription forms.

If the recipient is also restricted to a physician or clinic, this provider must order all non-emergency transportation services. If non-emergency transportation is necessary, dentists treating restricted recipients must contact the recipient's primary physician or clinic and request these services

RRP: Referrals

Primary providers may refer restricted recipients to other providers when necessary. When doing so, the primary dentist must give the servicing provider his/her MEDICAID provider ID number so that the servicing provider can perform the necessary EMEVS steps and properly submit claims.

Utilization Threshold

Under the Utilization Threshold Program, it is necessary for providers to obtain an authorization from the Medicaid Eligibility Verification System (MEVS) to render services for physician, clinic, laboratory, pharmacy, mental health clinic and dental clinic. This authorization to render services will be given unless a recipient has reached his/her utilization threshold limits. At this point, it will be necessary for an ordering provider to submit a special "Threshold Override Application" form in order to obtain additional services. In certain special circumstances, such as emergencies, providers do not have to receive authorization from MEVS. (See special instructions in the Billing Section of this Manual.) Arrangements have also been made to permit a provider to request a service authorization on a retroactive basis. In requesting a retroactive service authorization you risk your request being denied if the recipient has reached his/her limit in the interim. After you receive an authorization your claim may be submitted to our Fiscal Agent for processing. The regulation requiring claims to be submitted within 90 days of the date of service still applies.

- Laboratories and pharmacies may not submit a request for an increase in laboratory or pharmacy services. Such requests are to be submitted by the ordering provider. Laboratories which need to determine whether tests are needed on an emergency or urgent basis shall consult with the ordering provider, unless the order form indicates that an urgent or emergency situation exists.

- Those limited laboratory services which can be rendered by a physician or podiatrist in private practice to his/her own patients do not count toward the laboratory utilization threshold.

- Utilization Thresholds will not apply to services otherwise subject to thresholds when provided as follows:

  - "Managed care services" furnished by or through a managed care program, such as a health maintenance organization, preferred provider plan, physician case management program or other managed medical care, services and supplies program recognized by the Department to persons enrolled in and receiving medical care from such program;

  - Services otherwise subject to prior approval or prior authorization;

  - Reproductive health and family planning services including: diagnosis, treatment, drugs, supplies and related counseling furnished or prescribed by

or under the supervision of a physician for the purposes of contraception or sterilization. They also include medically necessary induced abortions, screening for anemia, cervical cancer, glycosuria, proteinuria, sexually transmissible diseases, hypertension, breast disease and pregnancy and pelvic abnormalities;

- Child/Teen Health Plan services;
- Methadone maintenance treatment services;
- Services provided by private practitioners on a fee-for-service basis to inpatients in general hospitals and residential health care facilities;
- Hemodialysis services;
- School health project services;
- Obstetrical services provided by a physician, hospital outpatient department, or free-standing treatment and diagnostic center; and
- Primary care services provided by a pediatrician or pediatric clinic.

The numbers of visits, lab procedures, medical supplies, drugs, and other items for each provider type are found in **Information For All Providers, General Policy**.

Section IV - Definitions

For the purposes of the Medicaid program and as used in this Manual, the following terms are defined to mean:

Attending Dentist

The attending dentist is the dentist who is primarily and continuously responsible for the treatment rendered.

Referral

A referral is the direction of a recipient to another practitioner for advice or treatment.