NYS Medicaid Dental Policies – All Stakeholder Webinar
Frequently Asked Questions (FAQ)

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New Guidance

Q: Where can I find a copy of the revisions?
A: The documents from which this presentation is derived can be found on eMedNY at

- clinical_criteria_guidance_dental_policy_-_11-17-23.pdf (emedny.org)
- updated_dental_manual_and_policy_-_11-8-23.pdf (emedny.org)

Q: When will the 2024 Manual be available on eMedNY?
A: The updated 2024 Dental Policy and Procedure Manual will be published on eMedNY January 31, 2024, and include codes and guidance on the new policies. Provider Manuals - Dental (emedny.org)

New Forms

Q: Where can I locate the *Justification of Need for Replacement Prosthesis Form* and *Evaluation of the Dental Implant Patient Form*?
A: These forms will be posted on eMedNY on January 31, 2024. Provider Manuals - Dental (emedny.org)

Q: Must the *Evaluation of the Dental Implant Patient Form* be sent in the same format or can a similar document with the information requested suffice?
A: The forms are required as provided.

Q: Will Academic Centers/Schools be required to complete these forms?
A: Yes. Both the new *Justification of Need for Replacement Prosthesis Form* and *Evaluation of the Dental Implant Patient Form* are required for all providers and must be maintained as part of the patient's dental record. The *Evaluation of the Dental Implant Patient Form* must accompany prior authorization requests. Those institutions that are not required to send for Medicaid fee-for-service prior authorization of removable prosthetics must complete the *Justification of Need for Replacement Prosthesis Form* and retain it as part of the patient record.

Eight Points of Posterior Contact

Q: Can you please define the meaning of 8 "points of contact?" If a patient has all 2nd and 3rd molars missing but they have all 1st molars and premolars, how many points of contact is that?
A: As utilized in the 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. In your example, if a patient has all eight premolars and four first molars present, they likely have greater than 8 points of posterior contact.

Q: It seems that the 8 points of contact criteria is now stated as "may be used." Can you expand on the word "may " in that context?
A: 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. 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. A crown and/or 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. Each case is professionally and individually evaluated on its own merit, when submitted for prior authorization with supporting documentation of current medical necessity. Some clinic facilities are not required to submit Medicaid fee-for-service prior authorization for certain procedures; it is required that they document case-specific medical necessity in the patient record.

Q: How do we understand the statement "presence or absence of 8 points of contact" in regard to implants? Is presence of 8 points of contact more likely to support molar implants, for example. Or is absence of 8 points of contact more likely to qualify for implants?
A: Dental Implants are considered Tooth Replacement and follow the same criteria regarding 8 points of posterior contact as other tooth replacements (i.e., removable partial dentures) in the Medicaid Dental Program. Each case will be professionally and individually evaluated on its own merit, based on supporting documentation of current medical necessity. Implant services require prior authorization and submission of the *Evaluation of the Dental Implant Patient Form*. Please refer to the policy for tooth replacement in the implant section of the manual.

Frequency Limits

Q: What is the frequency limit for crowns, dentures, sealants, and implants?
A: Please see frequency limits on the Medicaid Fee Schedule, columns E and F: Dental_Fee_Schedule.xls (live.com)

Q: For crowns, what is the filling frequency in order for it to be covered?
A: Each case is professionally and individually evaluated on its own merit, when submitted for prior authorization with supporting documentation of current medical necessity.

Conditions Precluding Extraction

Q: **What are the "medical conditions" that preclude extraction? Is there a list of diagnoses codes in the guidance documents? Please provide examples.**
A: These cases should be evaluated on an individual basis, weighing treatment benefits against the risks, and may require consultation with the member's physician. Possible examples include risk of osteonecrosis due to head and neck radiation or history of therapy with bisphosphonates, other antiresorptive drugs, or antiangiogenic drug therapy. The Department of Health will not be providing a comprehensive list of conditions which preclude tooth extraction.

Member Compliance

Q: What does "member compliance" mean and how will it be determined?

A: The concept of "member compliance" weaves disease prevention into the planning for dental services. Poor homecare or an inability to follow through with stabilizing the decay rate can lead to treatment failure. Advancing health equity requires educating patients about their options, and their role in treatment success, so they can make their own health care decisions. Health equity also requires recognizing that issues common to the Medicaid population, including poverty, unstable housing, and comorbidities may interfere with treatment success without representing a failure by the patient. When "member noncompliance" affects the prognosis of proposed treatment, the provider might alter the treatment plan or work with the member to understand and address barriers affecting treatment success.

Prior Authorization, Electronic Submission, Implant authorization

Q: How do we submit prior authorization?
A: Instructions for obtaining Medicaid fee-for-service prior approval are available online: PA Guidelines (emedny.org). Medicaid General Billing Guidelines are available online: INFORMATION FOR ALL PROVIDERS (emedny.org).

Q: **Will prior authorization requests sent prior to 1/31/24 be automatically reviewed for new guidelines or will they need to be resent?**
A: No. The new policies apply to prior authorizations and claims submitted on or after the effective date.

Q: In the case of a patient in pain, if the dentist wants to perform extractions with immediate implants, can prior authorization be submitted after the procedure?
A: Implants require prior approval along with the *Evaluation of the Dental Implant Patient Form*. Address the acute problem/pathology causing pain to stabilize the patient and allow prior authorization for implant-related services. For Medicaid fee-for-service prior authorization, once the Department of Health receives all required supporting documentation of medical necessity, the implant case will be evaluated. For Managed Care prior authorization, contact the specific Managed Care Organization with questions.

Q: Do you need a separate document for the narrative?
A: All required documentation must be submitted along with a prior authorization request, including any narrative supporting medical necessity. The 2024 Dental Manual will include a Prior Authorization checklist with requirements and suggestions for prompt processing of Medicaid fee-for-service requests.

Q: Is electronic submission available for Medicaid fee-for-service prior authorization requests? Does Medicaid fee-for-service accept electronic attachments?
A: Electronic submission of prior authorization requests and accompanying attachments is available. Please note: Currently electronic attachments cannot accompany electronic claims submissions. If you have an attachment to accompany a claim, a paper claim can be submitted.

Q: Will there be an upcoming webinar for use of the correct entity code within ePACES? Can I get training for billing crossover claims for both commercial and managed care plans? Can someone provide information on how to submit electronically on ePACES?
A: For information on how to enroll in the program for electronic submission, go to eMedNY : Tools Center, Self Help (emedny.org), or Selfhelp - ePACES General Information (emedny.org). Training sessions are available at Training - main (emedny.org) and Training - Contact Provider Outreach (emedny.org). For individualized assistance or to set up one-on-one training suited to your needs, call the eMedNY Call Center at 1-800-343-9000. One-on-one virtual Zoom training is available.
Instructions for checking a member's Medicaid eligibility: 5010_MEVS_Methods.pdf (emedny.org).

Q: Is an ICD-10 diagnostic code a requirement to submit with prior approval or on a claim?
A: For prior authorizations, narrative supporting medical necessity should include a diagnosis, either using medical terminology or ICD-10 coding. ICD-10 diagnosis codes are required for clinic/institutional Medicaid claims.

Q: Do we have to submit an *Evaluation of the Dental Implant Patient Form* with every implant pre-auth we submit?
A: Yes. This form should be submitted with the prior authorization request for the initial treatment plan.

Q: Can implant services be denied mid-treatment despite being pre-approved?
A: Once Medicaid fee-for-service has approved and reimbursed for the surgical stage of an implant, further stages would only be denied for poor prognosis. Please contact the Medicaid Managed Care plan for inquiries about prior authorization of Managed Care services.

Q: Will the restoration of a posterior tooth to prevent a free end saddle on a partial denture be considered a critical abutment?
A: Each case is professionally and individually evaluated on its own merit, when submitted with supporting documentation/current medical necessity.

Q: Does an academic dental center have to submit prior approval for all crowns, root canals and implants?
A: Implants (and implant-related services, including implant-supported crowns) and orthodontic services require prior authorization in all settings. Please contact the Medicaid Managed Care plan for inquiries about prior authorization of Managed Care services.

Q: If a patient previously received an implant fixture before coming to my office, can the second stage procedure be covered by the Medicaid program?
A: Each case will be professionally evaluated based on information provided. The case should be submitted for prior authorization with supporting documentation of current medical necessity and accompanied by the *Evaluation of the Dental Implant Patient Form.*

Q: Can we get a more detailed explanation regarding "rejected" and "inactivated" responses when we submit pre-authorizations?
A: For *Inactivated* responses, please see notes from the dental professional who reviewed the submission in the *Comments* section.
Rejected responses are typically generated by the *System* and will have *Systems* messages. Providers with questions regarding prior approvals and claims can call the eMedNY Call Center at 1-800-343-9000.

Q: Are mini-implants part of this plan?
A: Please refer to the provider manual at NEW YORK STATE DENTAL POLICY AND PROCEDURE MANUAL (emedny.org) for a list of implant codes covered under the program. All implant services require prior authorization along with the *Evaluation of the Dental Implant Patient Form* and are evaluated on a case-by-case basis.

Q: What if a tooth radiographically appears unopposed but the patient has a removable partial denture or complete denture opposing?
A: In addition to diagnostic radiographs, prior authorization requires accurate pre-treatment charting, a complete treatment plan, and the current condition of existing prosthetics. We encourage a narrative to include any supporting information to substantiate medical necessity or alert the reviewer of the presence of an existing functional appliance.

Excessive Treatment

Q: How are we to determine when treatment is considered to be excessive?
A: Assessment of cases will be reviewed on a case-by-case basis. Please include all required documentation and any additional information to support medical necessity when submitting prior authorization requests.
Prior authorization requests must include:

- Accurate pre-treatment charting
- Complete treatment plan of all proposed services
- Radiographs

Narratives supporting medical necessity should include a diagnosis. When reviewing requests for services, the following guidelines will be among factors taken into consideration in determining medical necessity:

- Caries index
- Periodontal status
- Recipient compliance
- Dental history
- Medical history
- Overall prognosis of the entire dentition
- Overall dental status of the recipient

Definitions

Q: How are functional and balanced occlusion defined? How is standard of care defined? What guidance will be used by DOH?
A: Please refer to published guidance from academic institutions or professional organizations for definitions. Using standards from Academic and Professional organizations, and taking into consideration the provider's narrative, each review will be made professionally and individually on a case-by-case basis, with supporting documentation of medical necessity.

Build-ups (core and post-and-core)

Q: Does a crown still include the core build-up? Often dental students do a build-up on a separate visit than the crown prep. How should those be billed/documented? Does a post and core D2954 code need preapproval?
A: In Medicaid fee-for-service, core build-up requirements are unchanged, and coverage remains included in the fee for the crown. Documentation should include diagnosis, treatment performed, and materials used. Post and cores do not require prior approval but should be included as part of the complete treatment plan. For requirements and reimbursement through Medicaid Managed Care, please review your contract with the plan.

Lower RPD (Removable Partial Denture) Criteria

Q/A: There is a typo in the guidance released in November 2023. It should read 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.
This will be corrected in the 2024 Dental Manual.

PACE (Program of All-Inclusive Care for the Elderly) Programs

Q: Does this apply to PACE programs?
A: Yes. These policies apply across all Medicaid lines of business.

Q: Does the requirement for Managed Care Organizations to use the listed forms (*Justification of Need for Replacement Prosthesis Form* and *Evaluation of the Dental Implant Patient Form*) include PACE organizations?
A: Yes. Both the new *Justification of Need for Replacement Prosthesis Form* and *Evaluation of the Dental Implant Patient Form* are required for all providers and must be maintained as part of the patient's dental record.

MCOs (Managed Care Organizations) and Child Health Plus Plans

Q: Do the new policies extend to Medicaid Managed Care?
A: Yes. These policies apply across all Medicaid lines of business, to include Medicaid Managed Care.

Q: Are these guidelines applicable to Essential Plan and Child Health Plus programs?
A: Essential Plan is updating its Model Language for subscriber agreements to incorporate dental benefit updates that are consistent with the updates in the Medicaid program. The updated Model Language for Essential Plan will be posted online.
https://info.nystateofhealth.ny.gov/2024invitation
For Child Health Plus members, please refer to the 2024 Dental Policy and Procedure Manual for guidance on members under age 21 at NEW YORK STATE DENTAL POLICY AND PROCEDURE MANUAL (emedny.org).

Q: Some Managed Care plans refuse to cover crowns for teeth with existing root canal if pre-treatment x-rays are not available. What is the policy on this?
A: Medicaid Managed Care Plans must follow the guidance regarding coverage of crowns for both children and adults. Guidance is found at clinical_criteria_guidance_dental_policy_-_11-17-23.pdf (emedny.org) and updated_dental_manual_and_policy_-_11-8-23.pdf (emedny.org).

Appeals/Fair Hearing Timetable

Q: What about service requests made before 1/31/2024?
Will the health plans, independent review organizations at the Division of Financial Services external appeal level, and Office of Temporary and Disability Assistance at the fair hearing level apply the rules in effect at the time-of-service request, date of review, date of initial adverse determination, or date of final adverse determination?
For example, would the new rules apply if the final agency decision is dated 1/31/24, but everything else came earlier?
A: New policies apply as of the effective date. These policies are not retroactive. Any treatment performed prior to January 31, 2024, follows the policy in effect at that time. Policies applied will be based on the policies active on the date the claim for treatment (date of service) or prior authorization was submitted.
Providers should resubmit prior authorizations after the effective date to be reviewed using new policies. A decision after fair hearing may remand the case if there is reason to believe that a remand would result in a more equitable determination. This may occur when there has been a material change in law or policy affecting the case.

Q: If a patient is seen the last week of January (before the 31st) and the new guidelines are more favorable for approval and therefore sent on/after 1/31/24 will they be reviewed based on submission date -or- are the reviewers going to apply prior guidelines?
A: Any treatment performed prior to the 1/31/24 effective date follows the old policies. The policies applied are based on the date of service for claims. These policies are not retroactive. Prior authorizations should be (re)submitted on/after 1/31/24 to be reviewed using the new policies.

Finding a Dentist

Q: Is there a list of dentists in my area who accept Medicaid?
A: Members looking to establish care can find lists of participating providers at the links below. If you are having difficulty finding a dentist and have Medicaid Managed Care (MMC) Plan, visit: NYS Provider & Health Plan Look-Up Tool. If you have Medicaid fee-for-service (FFS) Plan, visit: Medicaid Enrolled Provider Listing | State of New York (ny.gov), to find a dentist near you.

Q: One of the greatest hardships for enrollees is the lack of dental providers who accept Medicaid. Will there be any initiatives to outreach to dentists to participate in Medicaid?
A: The majority of Medicaid Members receive services through a Medicaid Managed Care Organization. These organizations have network requirements which are monitored for network adequacy.

Clinic Questions

Q: We are an Article 28 clinic. Will these expanded policies be available to our patients? What are our obligations for requesting prior authorization?
A: Yes, the policies apply to Article 28 facilities. Prior authorization will still be required for orthodontic and implant-related services for members with Medicaid fee-for-service coverage and for services for members with Medicaid Managed Care, as required by your contractual agreement.
The new *Justification of Need for Replacement Prosthesis Form* and *Evaluation of the Dental Implant Patient Form* are required to be completed for these services. Those institutions that are not required to submit prior authorization for removable prosthetics must retain the *Justification of Need for Replacement Prosthesis Form* as part of the patient record.

Q: **Do these changes apply to providers that receive Ambulatory Patient Group (APG) rates as well? Are Article 28 facilities who are reimbursed by Ambulatory Patient Groups (APGs) and handle prior approvals internally required to submit narratives for medical necessity? Will Article 28 facilities have to send a preauthorization request for orthodontic or implant services?**
A: Yes, the policies apply. Document medical necessity in the patient's treatment record. Orthodontics and dental implants/implant-related services are carved out of Ambulatory Patient Groups (APGs); they do require prior authorization with a narrative. Please see pages 20 and 21 of the APG manual.

Q: **Will Article 28 locations be able to call anyone for help with these changes as questions arise?**
A: Policy questions can be sent to dental policy at dentalpolicy@health.ny.gov. Facilities using APG methodology can send questions to APG@health.ny.gov. For Managed Care questions, please contact the Managed Care Organization.

Q: Is there someone we can speak with to walk us through how to submit electronically rather than by paper submission?
A: For information on how to enroll in the program for electronic submission, go to to eMedNY : Tools Center, Self Help (emedny.org), or Selfhelp - ePACES General Information (emedny.org). Training sessions are available at Training - main (emedny.org) and Training - Contact Provider Outreach (emedny.org). For individualized assistance or to set up one-on-one training suited to your needs, call the eMedNY Call Center at 1-800-343-9000. One-on-one virtual Zoom training is available.

Q: If we request prior authorization for dentures, will Medicaid fee-for-service give us an approval or denial instead of following Article 28 guidelines?
A: No. Article 28 facilities do not submit prior approval for dentures for Medicaid fee-for-service members. This policy remains unchanged.

Q: If Article 28 institutions are expected to continue to process prior authorizations for crowns and endodontic procedures, we will need to have a better understanding of what constitutes medical necessity.
A: When an Article 28 dental facility is determining whether a procedure is medically necessary, the following should be taken into consideration:

- Caries index
- Periodontal status
- Recipient compliance
- Dental history
- Medical history
- Overall prognosis of the entire dentition
- Overall dental status of the recipient

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.
For additional criteria to be used when determining medical necessity, refer to the specific sections of the Manual:

- Crowns (Section III)
- Endodontics (Section IV)
- Prosthodontics (Section VI)
- Implant Services (Section VIII)

Q: We are an Article 16 facility. We are currently a carve out. Will a prior approval be required for dentures, repairs, and replacements?

A: Dental implants/implant-related services and orthodontic services need prior authorization in Article 16 facilities, but Article 16 facilities are not required to send prior authorization requests for Medicaid fee-for-service dentures, prosthetic repair, or denture replacement services.

Additional Questions

Q: Would you clarify the use of sealants on 1st and 2nd molars and reapplication?
A: For Medicaid fee-for-service members, application of sealant is restricted to previously unrestored permanent first and second molars that exhibit no signs of occlusal or proximal caries for members between 5 and 15 years of age (inclusive). Buccal and lingual grooves are included in the fee. Reapplication, if necessary, is permitted once every five (5) years. Please refer to NEW YORK STATE DENTAL POLICY AND PROCEDURE MANUAL (emedny.org)

Q: Will root canal retreatment follow the same guidelines as root canal treatment?
A: Yes. There is new guidance for approval of root canals, but endodontic retreatment codes remain unchanged.

Q: Can Medicaid provide a history of the prosthesis?
A: The Department of Health does not provide a history of prosthetics to providers. In settings where prior authorization is not required (e.g., Article 28 facilities), providers are advised to document what the patient reports regarding the age of the prosthesis.