

Previous Medicaid Dental Benefit in NYS (Rules Effective for Services Requested Through 1/30/24)

New York's Medicaid program includes limited dental benefits. The coverage was expanded beginning on January 31, 2024 as the result of the settlement of the Ciaramella v. McDonald case (originally Ciaramella v. Zucker).

This article explains Medicaid dental rules in effect until January 31, 2024. These rules still apply to any requests for services made through January 30, 2024. If you are looking for more information about the Ciaramella v. McDonald case or the new rules regarding root canals, crowns, replacement dentures and dental implants that went into effect on January 31, 2024, please refer to [this article](#).

If you need advice about a specific Medicaid dental case, you can contact The Legal Aid Society's Access to Benefits helpline at (888) 663-6880.

THE BELOW RULES WERE IN EFFECT THROUGH 1/30/24. THEY APPLY TO ALL CARE REQUESTED THROUGH THAT DATE. IN CERTAIN CASES, IT MAY BE ADVISABLE TO RE-REQUEST SERVICES AFTER JANUARY 31, 2024.

WHAT DENTAL SERVICES ARE COVERED UNDER MEDICAID?

Medicaid Dental Coverage includes only "essential services," rather than comprehensive care. When reviewing requests for services the following general guidelines are used:

- Treatment will often not be approved when functional replacement with less costly restorative materials, including prosthetic replacement, is possible. Accordingly, there is often coverage for replacing but not treating a tooth. See Dental Policy and Procedure Code Manual, page 24.
- 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. See Dental Policy and Procedure Code Manual, page 24.
- Treatment such as endodontics (repeat root canal treatment) or crowns will not be approved in association with an existing or proposed prosthesis (artificial replacement) in the same arch, unless the tooth is a critical abutment (needed to attach a denture to) for a prosthesis provided through the NYS Medicaid program, or unless replacement by addition to an existing prosthesis or new prosthesis is not feasible. See Dental Policy and Procedure Code Manual, page 24.
- If the total number of teeth which require, or are likely to require, treatment would be considered excessive or when maintenance of the tooth is not considered essential or appropriate in view of the overall dental status of the recipient, treatment will not be covered. See Dental Policy and Procedure Code Manual, page 24.

- Treatment of deciduous teeth (primary or baby teeth) when exfoliation (when the primary teeth shed and the permanent teeth come in) is reasonably imminent will not be routinely reimbursable. See Dental Policy and Procedure Code Manual, page 24.
- Claims submitted for the treatment of deciduous cuspids and molars for children ten (10) years of age or older, or for deciduous incisors in children five (5) years of age or older will be pended for professional review. See Dental Policy and Procedure Code Manual, page 24.
- As a condition for payment, it may be necessary to submit, upon request, radiographic images and other information to support the appropriateness and necessity of these restorations. Extraction of deciduous teeth will only be reimbursed if injection of a local anesthetic is required. See Dental Policy and Procedure Code Manual, page 24.

CHILDREN'S DENTAL BENEFIT

A child is defined as anyone under the age of 21. Dental services for children are provided as part of Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. Under this program, children can receive periodic oral evaluations and preventive, restorative, and emergency dental care. The provider manual clarifies that this means children should receive routine preventive dental care every six months, and additional visits should be based upon the dentist's assessment of the child's individual needs. See EPSDT/CTHP Provider Manual for Child Health Plus A (Medicaid), page 12, <https://www.emedny.org/ProviderManuals/EPSDTCTHP/PDFS/EPSDT-CTHP.pdf>

MEDICAID ORTHODONTIC BENEFIT

The Medicaid Orthodontic Benefit is for children under 21 years old with severe physically handicapping malocclusions (a malocclusion is imperfect positioning of the teeth when the jaws are closed). The coverage is limited to three years of treatment and one year of retention care. Cleft palate or approved orthognathic surgical cases may be approved for additional treatment time. Treatment not completed within the maximum allowed period must be continued to completion without additional compensation for the NYS Medicaid program, the recipient, or the family. See Dental Policy and Procedure Code Manual, page 59.

INTERRUPTED TREATMENT POLICY

When an individual changes insurers (either fee-for-service to Medicaid managed care (MMC) or changes plans) in the midst of a course of treatment, the insurer at the time of the decisive appointment is responsible for the payment for the entire treatment. Claims must be submitted when the product or service is completed and delivered to the recipient with the appropriate procedure code using the date that the service was actually completed and delivered as the date of service. See pages 25-26 of the Dental Policy and Procedure Code Manual for a chart of the "decisive appointments" for various services.

THE FOLLOWING DENTAL SERVICES ARE EXCLUDED UNDER MEDICAID AND WILL NOT BE REIMBURSED

- â ¢ Fixed bridgework, except for cleft palate stabilization, or when a removable prosthesis would be contraindicated;
- â ¢ Immediate full or partial dentures;
- â ¢ Molar root canal therapy for beneficiaries 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 provided by the NYS Medicaid program;
- â ¢ Crown lengthening;
- â ¢ Replacement of partial or full dentures prior to required time periods unless appropriately documented and justified as stated in the Manual
- â ¢ Dental work for cosmetic reasons or because of the personal preference of the member or provider;
- â ¢ Dental work for cosmetic reasons or because of the personal preference of the recipient or provider;
- â ¢ Periodontal surgery, except when associated with implants or implant related services;
- â ¢ Gingivectomy or gingivoplasty, except for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects;
- â ¢ Adult orthodontics, except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts;
- â ¢ Placement of sealants for members under 5 or over 15 years of age;
- â ¢ Improper usage of panoramic images (D0330) along with intraoral complete series of images (D0210).

WHAT IF MEDICAID DENIES THE CLAIM?

- â ¢ Although Medicaid Dental is limited to essential services, if you believe your claim has been improperly denied, you may request a plan appeal (in Medicaid managed care) or a Fair Hearing.

RELEVANT REGULATIONS

- â ¢ 18 NYCRR 506.2: Dental Care:

- "Dental care in the medical assistance program shall include only preventive, prophylactic and other routine dental care, services and supplies, and dental prosthetic and orthodontic appliances required to alleviate a serious health condition including one which affects employability.
- For more information about what services are included, see the state regulation. 18 NYCRR 506.3
- Authorization for dental services and supplies: The identification card issued to persons eligible for medical assistance shall constitute full authorization for providing a select list of dental services and supplies and no special or prior authorization shall be required for these services.

- For information on which services do and do not require prior approval and authorization, click on this link to the regulation:

â ¢ 18 NYCRR 506.4: Orthodontic Care: For information on orthodontic care coverage, click on this link to the regulation.

â ¢ NYS Dental Policy and Code Manual: The rules and limitations for different dental services are included in the policy manual. Managed care plans, providers, and ALJs rely on the manual in determinations about dental coverage.

FAIR HEARINGS

General suggestions for succeeding at a fair hearing:

- Establish, through evidence, that the procedure is medically necessary.
 - ◆ Social Services law defines medical necessity as medical, dental, and remedial care, services and supplies which are necessary to prevent, diagnose, and correct or cure conditions in the person that may cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap. Social Services Law 365-a(2).
 - ◆ Provide as much evidence and medical documentation as possible of the need for and benefit of the work. Credible testimony by the appellant alone is not sufficient in these types of cases.
 - ◆ Decisions are often remanded, or sent back to the plan to make another determination, when the plan fails to provide support for their basis of denial.
 - ◆ Ask the dentist to testify during the fair hearing or to provide a written statement of a denial's impact on the client's health.
 - ◆ Use the American Dental Association's and New York State Dental Association's published materials to show that the Medicaid Manual is not following professional standards, such as a tooth is still viable and extracting it will cause health complications.
 - ◆ American Dental Association: <http://www.ada.org/en/>
 - ◆ New York State Dental Association: <http://www.nysdental.org/>

COMMON ISSUES

"8 Points of Contact" Rule:

- According to the Dental Policy manual, when considering if services are essential, eight posterior natural or prosthetic molars and/or bicuspid in occlusion will be considered adequate for functional purposes. This means that four maxillary (upper jawbone) and four mandibular (lower jawbone) teeth in functional contact with each other are considered adequate. Thus, if this is met, services may not be considered essential.
- Requests will be reviewed for necessity based upon the presence/absence of eight points of natural or prosthetic occlusal contact in the mouth (bicuspid/molar contact). See Dental Policy and Procedure Code Manual page 24.

- One missing maxillary anterior tooth (upper jawbone front tooth) or two missing mandibular anterior teeth (lower jaw front tooth) may be considered an esthetic problem that warrants a prosthetic replacement. See Dental Policy and Procedure Code Manual, page 24.
- One can challenge a determination that there are eight points of contact if the teeth that make up points of contact are damaged, diseased, or have moved.
- Provide as much documentation as possible to show that the procedure was (1) medically necessary and (2) that an insufficient number of teeth met the points of contact rule.
- Example: Agency denial was based on its determination that Appellant had 8 points of biting contact and the service requested was not covered due to the 8 points of contact rule, and not medically necessary. The denial was overturned because the Agency packet failed to include any information showing how the Agency made the factual finding as to the points of contact in Appellant's mouth. The record did not show where the teeth in need of treatment were and did not show which, if any, other teeth provided "biting contact." When contacted by phone at the hearing, the Agency was not available, having provided a contact phone number that was only a recording. FH# 6478476L (available [here](#))
- Example: Appellant was approved for placement of an upper denture but was denied for a lower partial denture. The Agency denial was upheld because the placement of the upper denture satisfied the 8 points of contact rule between the upper and lower back teeth. At the fair hearing the appellant's testimony of how she was unable to chew properly because of the constant pain and how that pain interfered with her capacity to perform the duties of her job was found to be credible. However, the appellant failed to establish that other treatments, even if less cosmetically ideal, would not eliminate the pain. Furthermore, the record failed to establish that the upper denture had yet been placed. Placement of the upper denture was expected to improve appellant's chewing ability. FH# 7261543K (available [here](#))
- Example: Agency denied appellant's request for a lower partial denture because the appellant had 8 points of contact without the denture. The appellant did not dispute that she had the 8 points of contact. However, the appellant stated that she suffered from Multiple Sclerosis, which paralyzed the right side of her mouth. Consequently, she could only use the left side of her mouth to eat. The agency's denial was affirmed because although the appellant's testimony indicated that she might have qualified for the partial lower denture, the appellant failed to present any medical documentation that proved her medical condition. FH# 6655671H (available [here](#))

Denture Replacement:

According to the Dental Policy manual 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 already been replaced once, then supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.

The Fair Hearings described below were decided based on a previous denture Policy, which expired Nov. 11, 2018 but may still be relevant and persuasive.

- Disease or extensive physiological change can include additional lost teeth, especially if an abutment for the current denture is lost or damaged. See, e.g., FH #6254420Y. (available [here](#))
- "Complete or partial dentures will not routinely be replaced when they have been provided by the Medicaid program and become unserviceable or are lost within eight years, except when they become unserviceable through extensive physiological change. If the recipient can provide documentation that reasonable care has been exercised in the maintenance of the prosthetic appliance, and it did not become unserviceable or lost through negligence, a replacement may be considered. Prior approval requests for such replacements will not be reviewed without supporting documentation. A verbal statement by the recipient that is then included by the provider on the prior approval request would generally not be considered sufficient."
- Example: Appellant's dentist requested prior authorization for denture replacement prior to the 8 year waiting period. Appellant testified that she lost her lower denture at home. Her looks and speech were unaffected but the lack of lower dentures were detrimental to her health because she was unable to eat the healthy diet required as an insulin-dependent diabetic. She was forced to eat by pressing food against her upper palate with her thumb. Agency denial upheld. Even though appellant could not eat the food she required for her diabetes, appellant presented no objective medical evidence to support her contention that her lack of the lower denture will cause her health to be compromised. Her testimony alone was insufficient; objective medical documentation is required. FH #6755535N. (available [here](#))
- Example: Appellant requested replacement of broken denture prior to the 8 year waiting period. Appellant testified he was taking the denture out at night to clean when he accidentally dropped it on the floor and two of the teeth broke off. The Appellant stated that with the denture being broken, he is left without any teeth, natural or otherwise, in his mouth. He further stated that without the lower denture, he cannot use the upper one because he will just be hurting his lower gum. Agency denial upheld. Though the Appellant accidentally broke the lower denture, dentures which are broken will not be replaced unless they become unserviceable through trauma, disease or extensive physiological change. FH# 7315399K (available [here](#))
- Exception: "Under certain circumstances the Agency will approve replacement of a lost partial denture, such as for a recipient whose mouth had undergone significant changes subsequent to the incident -- for example the loss of teeth." FH 6394357J (available [here](#))

Root Canals:

For beneficiaries age 21 and older, molar endodontic therapy will be considered when (1) the tooth in question is a critical abutment for an existing functional prosthesis and (2) the

tooth cannot be extracted and replaced with a new prosthesis. See Dental Policy and Procedure Code Manual, page 38.

Denials have been overturned for:

- Tooth is a critical abutment
- Example: Appellant's dentist submitted a prior authorization for root canal therapy on Appellant's tooth number 18 (molar). Appellant confirmed that she is not missing other teeth, all of her teeth are intact and healthy, and she does not have a bridge or denture for which tooth number 18 would serve as a critical abutment. However, the Appellant asserted that she is in extreme pain, and is unable to chew her food on the right side of her mouth (the side where tooth number 18 is located). The Appellant failed to establish that tooth number 18 is necessary to support a bridge or denture. Nor was she able to establish that extraction of tooth number 18 is contraindicated for health reasons. Because the tooth was not necessary to support any prosthetics, the Plan's determination to deny the requested root canal for tooth number 18 was upheld. FH# 7360626Q (available [here](#))
- Extraction is medically contraindicated
- Example: Fidelis (by DentaQuest) determined to deny the Appellant's dentist's prior approval request for a root canal on teeth numbers 2 and 18 on the ground that the service is not covered for members age 21 or older and that the service could be covered if pulling the tooth cannot be done because of a medical illness or if the tooth is needed for a bridge or a partial denture the Appellant already has. The plan further determined to deny the Appellant's dentist's prior approval request for a crown (D2751) on the same teeth on the ground that the root canal treatment was not approved. The record establishes that the Appellant's oral surgeon had advised by a letter dated March 11, 2015 that the Appellant not have any extractions, because, due to her "clenching and TMJ Disorder, any surgical extractions will worsen patient condition." Denial was reversed. FH# 7062037L (available [here](#))
- Medical necessity
- Example: On December 28, 2016 the Appellant's dentist requested prior authorization for a root canal on tooth number 15 (code D3330). On December 28, 2016 the Agency determined to deny the request on the grounds that the service is not covered by the Agency. The Agency did not review the Appellant's request based on whether the dentist's request for a root canal falls under the medically necessary guidelines. 18 NYCRR 513.0 provides that prior approval of medical, dental and remedial care, services or supplies is required under the MA program, such prior approval will be granted when the medical, dental and remedial care, services or supplies are shown to be medically necessary to prevent, diagnose, correct or cure a condition of the recipient. The denial was reversed. FH # 7484720Z (available [here](#))

MANY DENTAL CLINICS ARE COVERED UNDER MEDICAID

- In addition to a plan's network of dental providers, plan members have the right to

access dental services at the five New York Academic Dental Center clinics licensed under Article 28 of the NY Public Health Law

- Dental clinics are reimbursed on a rate basis or through Ambulatory Patient Groups (APGs) such as hospital outpatient departments, diagnostic and treatment centers, and dental schools, are required to follow the policies stated in the Dental Provider Manual. See Dental Policy and Procedure Code Manual, page 8.
- Dental services at these clinics may be accessed without prior approval and without regard to network participation.
- The plan must reimburse the clinic for covered dental services provided to enrollees at approved Medicaid clinic rates.

New York State Dental Centers:

- Columbia University College of Dental Medicine
- New York University College of Dentistry
- Stony Brook University School of Dental Medicine
- University of Buffalo School of Dental Medicine
- University of Rochester Eastman Dental Center

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<http://health.wnyc.com/health/entry/210/>