Summary of Benefits Report for New York, Medicaid
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Preventive Services

	Is the service Covered?	Frequency	List any service - specific limitations
Cleanings	Yes	1 x 6 months	An additional prophylaxis may be considered within a twelve (12) month period for those individuals identified with a Restriction Exception code of RE 81 (“TBI Eligible”) or RE 95 (“OPWDD/Managed Care Exemption”). The additional prophylaxis should be submitted using the appropriate procedure code (D1110 or D1120). Documentation supporting necessity must be submitted with the claim. Reimbursement will not be considered if performed within a four-month interval of previous prophylaxis (D1110, D1120) or D4910.
Fluoride treatments (including fluoride varnishes)	Yes	1 x 3 months	D1206 -Reimbursable once per three (3) month period for members, from eruption of first tooth through age 20 (inclusive). For individuals 21 years of age and older D1206 is only approvable for those individuals identified with a Restriction Exception code of RE 81 (“TBI Eligible”) or RE 95 (“OPWDD/Managed Care Exemption”), or, in cases where salivary gland function has been compromised through surgery, radiation, or disease. D1208 - Reimbursable once per six (6) month period for members between 6 and 20 years of age (inclusive). Fluoride must be applied separately from prophylaxis paste. For individuals 21 years of age and older D1208 is only approvable for those individuals identified with a Restriction Exception code of RE 81 (“TBI Eligible”) or RE 95 (“OPWDD/Managed Care Exemption”), or, in cases where salivary gland function has been compromised through surgery, radiation, or disease

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Preventive Services

	Is the service Covered?	Frequency	List any service - specific limitations
Sealants (list any tooth-specific limits)	Yes - only with prior authorization	1 x every 5 years	Mechanically and/or chemically prepared enamel surface sealed to prevent decay. Refer to the “Prior Approval/Prior Authorization Requirements” section for use of DVS. Application of sealant is restricted to permanent first and second molars with unrestored occlusal surfaces that exhibit no signs of occlusal or proximal caries for members between 5 and 15 years of age (inclusive). Application to occlusal pits and fissures, as well as contiguous buccal and lingual grooves are included in the fee. The use of opaque or tinted sealant is recommended for ease of checking bond efficacy. Reapplication, if necessary, is permitted once every five (5) years. Prior authorization is required through the use of the Dispensing Validation System (DVS) when specified. These specifications are indicated after the procedure code description by the following: (DVS REQUIRED)
Space maintainers	Yes	1 x year	Only fixed appliances are reimbursable. Documentation including pre-treatment images to justify all space maintenance appliances must be available upon request. Space maintenance should not be provided as an isolated service. All carious teeth must be restored before placement of any space maintainer. The member should be practicing a sufficient level of oral hygiene to ensure that the space maintainer will not become a source of further carious breakdown of the dentition. All permanent teeth in the area of space maintenance should be present and developing normally. Space maintenance in the deciduous dentition (defined as prior to the interdigitation of the first permanent molars) can generally be considered. Space maintenance in the mixed dentition initiated within one month of the necessary extraction will be reimbursable on an individual basis. Space maintenance in the mixed dentition initiated more than one month after the necessary extraction, with minimum space loss apparent, may be reimbursable.

Diagnostic Services

	Is the service Covered?	Frequency	List any service - specific limitations	Recommended age of first visit ?
Oral health screening or assessment	Yes		When oral assessments are provided by a registered dental hygienist, in accordance with a	

Diagnostic Services

	Is the service Covered?	Frequency	List any service - specific limitations	Recommended age of first visit ?
			collaborative practice agreement, Medicaid will reimburse Article 28 clinics for these assessments. A dental hygienist screening of a patient should be billed using D0190. The clinic should bill for any other procedures provided by the hygienist within their scope of practice (e.g., prophylaxis). These claims will be identified by the D0190 code to indicate that a dental hygienist performed the services provided. Please note that D0190 should only be billed for screening performed by a dental hygienist.	
Dental examinations	Yes	1 x 6 months	An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the patient. Report additional diagnostic procedures separately. Reimbursement is limited to once per six (6) month period	no minimum age specified
Assessment of risk for tooth decay	No			
X-Rays				

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Diagnostic Services

	Is the service Covered?	Frequency	List any service - specific limitations	Recommended age of first visit ?
Bitewing	Yes	2 x year	Minimum age 2 years for 1 BWX, 2 BWX and minimum age 6 for 3 BWX, 4 BWX	
Full Mouth	Yes	1 x every 3 years	Minimum age 12 years - Radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. This can be used for complex treatment planning and diagnosis of periapical or periodontal pathology. This code is not reimbursable when a panoramic image has been taken within three years, except when medically necessary for the diagnosis of a new patient or new condition. For purposes of the NYS Medicaid program, an intraoral, comprehensive series (full mouth) consists of at least ten (10) periapical films plus bitewings.	

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Diagnostic Services

	Is the service Covered?	Frequency	List any service - specific limitations	Recommended age of first visit ?
Panoramic	Yes	1 x every 3 years	Minimum age 2 years. Reimbursable every three years if clinically indicated. For use in routine caries determination, diagnosis of periapical or periodontal pathology only when supplemented by other necessary radiographic intraoral images (bitewing and/or periapical), completely edentulous cases, diagnosis of impacted teeth, oral surgery treatment planning, or diagnosis of children with mixed dentition. Postoperative panoramic images are reimbursable for post-surgical evaluation of fractures, dislocations, orthognathic surgery, osteomyelitis, or removal of unusually large and/or complex cysts or neoplasms. Panoramic radiographic images are not required or reimbursable for post orthodontic documentation. Panoramic images are not reimbursable when an intraoral complete series or panoramic image has been taken within three years, except for the diagnosis of a new condition (e.g., traumatic injury, orthodontic evaluation). A treating dental specialist can be reimbursed for a panoramic radiograph (panorex) even if one has been taken within three years, to render the necessary dental care when the panorex provided from the	

Diagnostic Services

	Is the service Covered?	Frequency	List any service - specific limitations	Recommended age of first visit ?
			referring dentist is not diagnostic or cannot be obtained. Claims for payment should be accompanied by a narrative explaining the patient-specific medical necessity.	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Anti-microbial treatments that stop decay from spreading	Yes		Limited to Silver Diamine Fluoride (SDF) Clinical criteria for the use of silver diamine fluoride: • Stabilize non-symptomatic teeth with active carious lesion and no pulpal exposure • High caries risk (e.g. xerostomia, severe early childhood caries) • Treatment challenged by behavioral or medical management • Difficult to treat carious lesions Criteria for reimbursement: • Covered two (2) times per tooth within a 12-month period with a total of four (4) times per lifetime of the tooth. • Covered with topical application of fluoride (“D1206” or “D1208”) when they are performed on the same date of service if “D1354” is being used to treat caries and “D1206” or “D1208” is being used to prevent caries. • Silver diamine fluoride may be applied to five (5) teeth on the same date of service with more teeth considered in exceptional circumstances.	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
			Documentation supporting necessity must be submitted with the claim. • Caries arresting medicament is not reimbursable when used as a base for a final restoration. Providers are required to: Fully disclose the risks and benefits of silver diamine fluoride use and to discuss treatment alternatives where appropriate. Obtain written consent.	
Fillings				
Silver amalgam	Yes		Restorations placed solely for the treatment of abrasion, attrition, erosion or abfraction and are not associated with the treatment of any other pathology are beyond the scope of the program and will not be reimbursed. Restorative procedures should not be performed without documentation of clinical necessity. Published “frequency limits” are general reference points on the anticipated frequency for that procedure. Actual frequency must be based on the clinical needs of the individual member	

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Treatment Services				
	Is the service Covered?	**Frequency**	**List any service - specific limitations**	**Criteria for coverage**
Tooth colored composite	Yes		Restorations placed solely for the treatment of abrasion, attrition, erosion or abfraction and are not associated with the treatment of any other pathology are beyond the scope of the program and will not be reimbursed. Restorative procedures should not be performed without documentation of clinical necessity. Published “frequency limits” are general reference points on the anticipated frequency for that procedure. Actual frequency must be based on the clinical needs of the individual member	
Crowns/tooth caps				
Stainless steel crowns	Yes		For all prefabricated crowns (D2930, D2931, D2932, D2933, D2934) there must be supporting documentation substantiating the need for the crown (e.g. radiographic images).	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Metal (only) crowns	Yes - only with prior authorization		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	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
			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: 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	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Metal/porcelain crowns	Yes - only with prior authorization		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	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
			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: 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	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Porcelain (only) crowns	Yes - only with prior authorization		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	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
			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: 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	
Root Canals (endodontics)				
Root canals on baby teeth (pulpotomies)	Yes		To be performed on primary or permanent teeth up until the age of 21 years.	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Root canals on permanent teeth	Yes - only with prior authorization		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: o The periodontal status, member compliance and overall status and prognosis of the tooth is favorable 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	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
			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: o The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Gum (periodontal) therapy	Yes		Minimum Age for D4341, D4342 is 13 years. Requires PA if quadrant treated > once (1) in twenty-four (24) month period. For periodontal scaling and root planing (D4341 and D4342) to be considered, the diagnostic materials must demonstrate the following, consistent with professional standards: • Clinical loss of periodontal attachment, and; o Periodontal pockets and sub-gingival accretions on cemental surfaces in the quadrant(s) being treated, and/or; o Radiographic evidence of crestal bone loss and changes in crestal lamina dura, and/or; o Radiographic evidence of root surface calculus. The provider must keep in the treatment record detailed documentation describing the need for periodontal scaling and root planing, including a copy of the pre-treatment evaluation of the periodontium, a general description of the tissues (e.g., color, shape, and consistency), the location and measurement of periodontal pockets, the description of the type and amount of bone loss, the periodontal diagnosis, the amount and location of subgingival calculus deposits, and tooth mobility	
Dentures				

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Partial dentures	Yes - only with prior authorization		Minimum age: 15 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.	
Complete dentures	Yes - only with prior authorization		Minimum age: 18 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.	

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Bridges	Yes - only with prior authorization		Services not within the scope of the Medicaid Program except for cleft palate stabilization, or when a removable prosthesis would be contraindicated.	
Orthodontics*				
Retainers (orthodontic)	Yes - only with prior authorization		Age 5 up to 21 years	
Braces	Yes - only with prior authorization		Eligibility is limited to members who: 1. are under 21 years of age; 2. meet financial standards for Medicaid eligibility; and, 3. exhibit a SEVERE PHYSICALLY HANDICAPPING MALOCCLUSION. Orthodontic care for severe physically handicapping malocclusions is a once in a lifetime benefit that will be reimbursed for an eligible member for a maximum of three years of active orthodontic care, plus one year of retention care. Retreatment for relapsed cases is not a covered service. Treatment must be approved, and active therapy begun (appliances placed and activated) prior to the member's 21st birthday. Treatment of cleft palate or approved orthognathic surgical cases may be approved after the age of 21 or for additional treatment time.	HLD Index Report of 26 or greater
Oral surgery				
Simple extractions	Yes			
Surgical extractions	Yes			
Care of abscesses	Yes		Report needed documenting medical necessity	

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Cleft palate treatment	Yes		Report needed documenting medical necessity.	
Cancer treatment	Yes		D1206 Topical application of fluoride varnish Reimbursable once per three (3) month period for members, from eruption of first tooth through age 20 (inclusive). For individuals 21 years of age and older D1206 is only approvable for those individuals identified with a Restriction Exception code of RE 81 (“TBI Eligible”) or RE 95 (“OPWDD/Managed Care Exemption”), or, in cases where salivary gland function has been compromised through surgery, radiation, or disease.	
Treatment of fractures	Yes		Report is needed documenting medical necessity	
Biopsies	Yes		Report is needed documenting medical necessity	
Treatment of jaw joint problems (TMJ)	Yes		Report is needed documenting medical necessity	
Emergency room services provided by a dentist	Yes			
Inpatient Hospital Services	Yes			
Anesthesia				

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
General anesthesia	Yes		Unless otherwise specified, the cost of analgesic and anesthetic agents is included in the reimbursement for the dental service. Reimbursement for general anesthesia, intravenous (parenteral) sedation, and anesthesia time is conditioned upon meeting the definitions listed below. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the member. Anesthesia services are considered completed when the member may be safely left under the observation of trained personnel and the doctor may safely leave the room. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effect upon the central nervous system and not dependent upon the route of administration. Appropriate NYSED certificate is REQUIRED. Please see guidance on Record Keeping. Anesthesia time should be commensurate with the treatment performed. nesthesia time is divided into 15-minute units for deep sedation/general anesthesia and intravenous sedation/analgesia for billing purposes;	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
			the number of such units should be entered in the "Times Performed" field of the claim form using the appropriate code (D9223, D9243).	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Intravenous conscious sedation	Yes		Unless otherwise specified, the cost of analgesic and anesthetic agents is included in the reimbursement for the dental service. Reimbursement for general anesthesia, intravenous (parenteral) sedation, and anesthesia time is conditioned upon meeting the definitions listed below. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the member. Anesthesia services are considered completed when the member may be safely left under the observation of trained personnel and the doctor may safely leave the room. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effect upon the central nervous system and not dependent upon the route of administration. Appropriate NYSED certificate is REQUIRED. Please see guidance on Record Keeping. Anesthesia time should be commensurate with the treatment performed. Anesthesia time is divided into 15-minute units for deep sedation/general anesthesia and intravenous sedation/analgesia for billing purposes;	

Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
			the number of such units should be entered in the "Times Performed" field of the claim form using the appropriate code (D9223, D9243)	
Non-intravenous conscious sedation	Yes		Current Dental terminology (CDT) code D9230, D9244, D9245, and D9246 are reimbursable for members/enrollees through 20 years of age (inclusive) in conjunction with covered dental services, with documentation of the patient-specific diagnosis or behavior indicating clinical necessity. Codes D9230, D9244, D9245, and D9246" are not billable when another billable method of anesthesia/analgesia/ sedation (i.e., "D9222", "D9223", "D9239", and "D9243") is used during an encounter. When "D9230" and " D9244, D9245, D9246" are used together, only one is reimbursed. For members/enrollees 21 years of age and older, D9230, D9244, D9245, and D9246 are only approvable for those members/enrollees identified with a Restriction Exception code of RE “81” (Traumatic Brain Injury Eligible) or RE “95” [Office of Persons with Developmental Disabilities (OPWDD)].	

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Treatment Services

	Is the service Covered?	Frequency	List any service - specific limitations	Criteria for coverage
Analgesia (nitrous oxide)	Yes		Current Dental terminology (CDT) code D9230, D9244, D9245, and D9246 are reimbursable for members/enrollees through 20 years of age (inclusive) in conjunction with covered dental services, with documentation of the patient-specific diagnosis or behavior indicating clinical necessity. Codes D9230, D9244, D9245, and D9246" are not billable when another billable method of anesthesia/analgesia/ sedation (i.e., "D9222", "D9223", "D9239", and "D9243") is used during an encounter. When "D9230" and " D9244, D9245, D9246" are used together, only one is reimbursed. For members/enrollees 21 years of age and older, D9230, D9244, D9245, and D9246 are only approvable for those members/enrollees identified with a Restriction Exception code of RE “81” (Traumatic Brain Injury Eligible) or RE “95” [Office of Persons with Developmental Disabilities (OPWDD)].	

* When this information is posted on the Insure Kids Now website, we will include a special note for orthodontic services explaining that parents and caretakers should work with their child's orthodontist to ensure that the treatment and payment terms and conditions are clear at the outset of treatment (for example, what happens in the case of a child who becomes ineligible for Medicaid or CHIP while he or she is undergoing orthodontic treatment?).