

## New York State Department of Health

Question and Answer Sheet Resulting from June 12<sup>th</sup>, 2012 Webinar:  
Transition of Dental and Orthodontia Coverage from Fee for Service to Medicaid Managed Care

### ***Dental***

<b>Question</b>	<b>Answer</b>
1. What is a "decisive appointment"?	Certain dental procedures require multiple visits to complete (e.g., root canals, crowns, bridges). When the beneficiary's insurance changes in the middle of a multi-visit procedure, the entire procedure is reimbursed by the insurer responsible as of the date of the decisive appointment. See the Medicaid Dental Policy & Procedure Manual at <a href="https://www.emedny.org/ProviderManuals/Dental/index.aspx">https://www.emedny.org/ProviderManuals/Dental/index.aspx</a>
2. If I already have dental prior authorization from FFS but have not reached decisive appointment, must I stop treatment and reapply for a new pre-authorization from the new MMC plan?	Yes. All <u>dental</u> prior authorizations/prior approvals received under Medicaid fee-for-service prior to 7/2/2012 are null and void as of 7/2. You will need to get a new authorization from the member's health plan.
3. I am a general dentist, how will this affect me in my practice? Will I have to join all managed care plans? If yes, How will I do that?	You do not need to join all managed care plans, however, you will need to participate with a specific member's Medicaid managed care (MMC) plan to continue treating that member after any applicable transitional care period. Contact information for the Dental Benefits Managers and the MMC plan that directly administers the dental benefit is posted along with these Q&As.
4. Is there still going to be Dental Coverage for people with straight Medicaid?	For persons that are NOT enrolled in Medicaid managed care, there will still be a dental benefit in FFS.
5. With respect to the Academic Dental Centers, will the only dental services that require prior authorization from a MMC plan/or the State be orthodontia? Assuming this is the case, how would the prior approval process work for an ADC that is a non-par provider providing services for a MMC plan enrollee?	Academic Dental Centers do not need to obtain prior approval from MMC plans or the State for any non-orthodontic dental services or for orthodontic exams and evaluations. For <b><i>orthodontic treatment</i></b> , the Center should contact the appropriate Dental Benefits Manager (specific to the plan in question) or the health plan itself to request prior approval.
6. Is there a list of Academic Dental Centers?	Eastman (Rochester), Daniel Squire (SUNY Buffalo), Columbia

	University, New York University, and SUNY Stony Brook. The billing provider in each case is a free-standing diagnostic and treatment center affiliated with a dental school or certifying institution.
7. If the managed care plan does not have dental, does Medicaid FFS cover dental?	For Medicaid managed care, all plans will be covering the dental benefit statewide. This includes the HIV/SNPS. For FHPlus, if a plan does NOT choose to cover dental, there is no FFS coverage for dental services.
8. Does the decisive appointment rule apply to article 28 facilities?	Yes.
9. Will all pre-approval have to be resubmitted if treatment is not started by July 1?	Yes.
10. Do MMC patients needing dentures require prior approval or medical justification letters (new or redo within 8 years)?	MMC plans may establish their own requirements for prior approval and documentation.
11. Is it possible for beneficiaries to be enrolled in one MMC plan for medical needs and another for dental coverage? What will we see in ePACES or on-line eligibility? Is medical and dental separate?	You can only be enrolled in ONE managed care plan at a time, and that plan will be responsible for both medical and dental care. You will see the managed care enrollment in ePACES. Effective 7/2/12, all MMC plans will cover the dental benefit.
12. How will DOH determine an "adequate network" of dental providers?	Dental networks require general dentists, pedodontists and oral surgeons. The requirement is to have a minimum of at least 2 of each provider specialty in each county. The network has to be geographically accessible to the members where there is adequate availability of providers. Managed care organizations are also required to ensure the general dentist to patient ratio does not exceed 1:2000.
13. Will patients have two insurance cards, one for dental managed care and another card for primary care services?	Some plans issue a separate card for dental services, others use one card for both medical and dental services.
14. Is an Article 28 Hospital with a dental residency program the same as an Academic Dental Center?	No. By statute, and ADC is a free-standing clinic (not hospital based) affiliated with a dental school or certifying institution.
15. If a client is in capitation guarantee, is the plan responsible to provide dental services until the end of the guarantee?	Yes.

16. We work with a FHP plan that doesn't cover dental. Will they cover as of 7/1/12?	There are a few FHP plans that will include dental as of 7/1. You should check with the plans you participate with.
17. Have all of the dentists that participate with Medicaid been notified of the 7/1/12 transition? If yes, how were they notified?	Dental practitioners were notified via this webinar, as well as the April 2012 Medicaid Update. Information has also been posted to the MRT webpage. eMedNY will also be posting a reminder to all dental and orthodontia practitioners.
18. How do we treat patients that come in with urgent pain and/or infection?	Providers should follow the MMC plan's rules regarding notification to the plan for emergency and urgently needed services.
19. If the patient is a MMC member, can they still access the Academic Dental Ctr. for their care - even if the ADC is not "in-network" with the MMC plan?	Yes, MMC members have free access to Academic Dental Centers, regardless of whether the Center participates in the plan's network.
20. Article 28 dental clinics are currently exempt from obtaining prior authorizations. Will we still be exempt after the transition happens or will it be up to each MMC plan?	Only Academic Dental Centers are exempt from prior approval requirements for dental services. MMC plans make their own determinations as to what services require prior approval. For beneficiaries covered through FFS, all Article 28 facilities will remain exempt from prior approval requirements (except for orthodontic treatment).

***Orthodontia***

<b>Question</b>	<b>Answer</b>
21. For orthodontic services, is there an expiration date for the approval received prior 10/1/12? If for any reason the patient is not available to be bonded before 10/1/12.	The expiration date is indicated on the approval and is generally 18 months from the date of approval.
22. When will the orthodontia providers of NYC receive the eMedNY PA# for the existing patients and how will we receive it? By mail or email?	Beginning in July, providers will begin receiving PA numbers for treatment approved by NYCORP. The PA will go to the provider by U.S. mail.
23. What will the process be for current NYC orthodontic patients regarding the annual review?	The provider will need to obtain PA for second and third year treatment and retention from Albany. Documentation of progress and medical necessity is required. See page 56 of the Dental Policy and Procedure Codes Manual

	<a href="https://www.emedny.org/ProviderManuals/Dental/index.aspx">https://www.emedny.org/ProviderManuals/Dental/index.aspx</a>
24. What standard will be used for adequate networks of orthodontists in NYC is it also 2 per county?	The network requirement is a <u>minimum</u> of 2 orthodontists per county. This is a minimum requirement dependent upon the size of the county and the geographic accessibility to members residing in the counties. In some areas of the state there may be a lack of orthodontists making this provider type unavailable to members. Where orthodontists are unavailable or not geographically accessible to members in the county the analysis will determine whether there are orthodontists within 30 minutes/30 miles of members.
25. For orthodontia, after 10/01/12. Do we have to request the approval for orthodontia treatment with the form EMEDNY361401 or an ADA claim form?	Procedures for requesting prior approval will be determined by each MMC plan.  Prior approval requests for orthodontic treatment for beneficiaries covered through FFS must be submitted on the paper EMEDNY361401 or electronically in a HIPAA compliant 278 transaction such as ePACES.
26. As a provider do you enroll with the different insurances (Metro Plus, Fidelis, etc.) or only to the vendor (Dentaquest or Healthplex)?	We have attached the list of contacts for information concerning contracting with a plan.
27. For orthodontics, do we have to participate with other providers, in order to get paid as an out of network provider?	Out of network providers may be paid by a MMC plan <b>only</b> during a transitional care period <b>or</b> with prior approval from the plan.
28. Can each plan choose where to send orthodontic cases?	The member can choose the orthodontist using the plan's list of contracted network providers.
29. If we only have a PA for 1st year orthodontia and the patient is FFS, can we obtain the next year PA or is the patient still FFS?	FFS requires PA for second and third year treatment and retention. If the patient was approved through FFS all prior approvals and payments will continue FFS to the conclusion of the approved course of orthodontic treatment. See page 56 of the Dental Policy and Procedure Codes Manual <a href="https://www.emedny.org/ProviderManuals/Dental/index.aspx">https://www.emedny.org/ProviderManuals/Dental/index.aspx</a>
30. If we are a FFS orthodontist, will we be able to continue as usual with any new FFS	All new clients NOT enrolled in Medicaid managed care may be served under the

patient after 10/1/12, meaning can we "start" a new PA process or can we no longer see any new patients?	procedures and policy outlined in the "Dental Policy and Procedure Manual." For new patients that are enrolled in a MMC plan, you must work with the health plan. FFS will deny payment for services provided to MMC members.
31. Are all MMC plans providing Orthodontia Services?	Yes, as of October 2012, all Medicaid managed care plans and HIV/SNPS will be covering the benefit.
32. Is there a cutoff age for orthodontia services?	Orthodontia treatment must start before age 21.
33. Will general dentists and pediatric dentists be able to perform orthodontic treatment under managed care? Or is this only available for orthodontists?	The services a general or pediatric dentist may provide to an MMC plan's members will be articulated in the provider contract.
34. What is the MCO's turnaround time to process a request for orthodontia? I thought it was 3 business days for dental. Is it longer for orthodontia?	Utilization review determinations for the preauthorization of services are required to be made within 3 business days, or as the condition requires (i.e. emergency), from receipt of the necessary information.
35. For orthodontic patients that are in the middle of treatment, will FFS pay only through the end of the current year of treatment that was approved or does FFS pay to complete the full 3 years of orthodontic treatment plus retention care?	For members who were prior approved for orthodontic treatment before 10/1/12, Medicaid fee-for-service will continue to cover through the duration of treatment and retention.
36. For orthodontia, what situations would allow for a FFS patient after the new rules go into effect?	If the client is NOT enrolled in a MMC plan, providers will bill FFS.
37. I am currently a certified orthodontist renting space in a general practice office. Can I treat Medicaid patients in that office?	Orthodontists must be enrolled in the FFS Medicaid program to receive FFS payment. Ownership and disclosure requirements must be met as a condition of enrollment and ongoing participation. Renting space is allowed for FFS providers and the provider must meet all professional and Medicaid standards and requirements including record keeping, patient care and billing.

**Billing**

Question	Answer
38. If the MMC plan does not have the APG groupers, are the Academic Health Centers	No, the MMC plans are responsible for paying Academic Dental Centers for services provided to

still going to bill Medicaid directly?	plan members.
39. Currently our ADC (paid via APG) submits claims to Medicaid using the 837I format. Can we continue to use the 837I format when billing the managed care plans?	Each MMC plan will determine its own policies and procedures for billing.
40. If patient's 3rd party insurance does not cover orthodontia, can we bill Medicaid FFS?	Providers may bill Medicaid fee-for-service ONLY if the client is NOT in an MMC plan. Prior approval is required from either FFS or the MMC plan.
41. If you are an article 28 facility do you bill the managed care plan or, instead, bill Medicaid directly?	All providers, including Article 28 facilities, should bill: <ul style="list-style-type: none"> <li>• Medicaid fee-for-service for patients who are NOT enrolled in an MMC plan, as well as for orthodontia patients who received a PA from FFS prior to 10/1/12; and</li> <li>• The MMC plan for dental patients enrolled in an MMC plan and for orthodontia patients who received a PA from the plan on or after 10/1/12.</li> </ul>
42. If a patient was approved under Medicaid for oral surgery and they come in after July 1st and their plan has changed, can they still have the oral surgery and will it be covered under MA FFS?	If the oral surgeon does not participate with the member's MMC plan, and there is a treatment plan in progress, the provider may continue to treat the member during the transitional care period contingent upon the provider agreeing to adhere to the MMC plan's requirements.
43. Can you please confirm that, with respect to the Academic Dental Centers and the Open Access Rule, the rate the ADCs will be paid by the MMC plans for services provided is the APG rate for Academic Dental Centers, and not a separate FFS rate? Assuming this is the case, can you also confirm that with respect to payments made to Academic Dental Centers, whether by a MMC plan or the state, that all references to "FFS rate" mean the APG rate?	Yes, Academic Dental Centers will be paid the APG rate by MMC plans. In this case, "FFS" means APGs, except for orthodontic exams and evaluations, which would be paid at the fee schedule rate (procedure codes D8660, D0340, D0330, D0210, D0470 and D0350).
44. Can you please confirm that the carve-out for the Academic Dental Centers, under the Open Access Rule (364-j (d) (4)) is still in effect and continues to allow ADCs to treat	State law gives MMC members "free access" to Academic Dental Centers, i.e., members may access services at these Centers directly regardless of whether the Center is in the MMC

<p>MMC enrollees and bill the MMC plan at the APG rate for services provided without need for prior approval from the MMC plan and without respect for whether the ADC is a par provider?</p>	<p>plan’s network. This free access policy remains in place. Plans may not require prior approval for dental services and orthodontic exams and evaluations. However, <b>plans may require prior approval for orthodontic treatment</b>. MMC plans must pay non-participating Centers for these free access services at the APG rate. Participating Centers would be paid at the contracted amount.</p>
<p>45. Can you please explain how Academic Dental Clinics (ADCs) will bill for services provided when a Medicaid enrollee whom they have treated has not yet selected or enrolled in a MMC plan—would the ADC just bill the state for the FFS rate (the APG rate)? What if the enrollee is just in FFS Medicaid?</p>	<p>Nothing changes for beneficiaries who are NOT enrolled in an MMC plan. When providers treat patients who are not enrolled in an MMC plan, the provider should bill the State as they do now. However, enrollment status may change as of the first day of any month, so providers should check eligibility <b>at every visit</b> to ensure payment is received for services.</p>
<p>46. If we have a PA for third molar extractions prior to 7/1/12, but surgery is not done until after 7/1/12, and patient is switched to plan we do not participate with, would this still be paid as FFS?</p>	<p>All dental prior authorizations/prior approvals received under Medicaid fee-for-service prior to 7/2/2012 are null and void as of 7/2. You will need to get a new authorization from the member’s health plan unless the transitional care period applies, i.e., if you do not participate with the member’s MMC plan, and there is a treatment plan in progress, you may continue to treat the member during the transitional care period as long as you have agreed to adhere to the MMC plan’s requirements.</p>
<p>47. How do we identify what payer(s) are requiring APG versus FFS claims? i.e. Fidelis (an APG payer) does not cover dental for Otsego County. Dentaquest will be their dental plan. Are the Dentaquest claims FFS professional claims or APG facility claims?</p>	<p>The Dental Benefits Managers (Healthplex, DentaQuest and DPBScion) administer the dental benefit on behalf of MMC plans and will reimburse according to the MMC plan’s reimbursement policies. Reimbursement will be negotiated as part of the provider contracting process.</p>
<p>48. Effective 7/1, there will be no more straight Medicaid for any patients correct? If we choose not to have contracts with the insurance companies, do they have to pay us our current APG rates?</p>	<p>Over the next few years, many people who were previously not required to enroll in Medicaid managed care will be mandatorily enrolled. However, FFS Medicaid will continue throughout this period, although the number of people who will remain in FFS will decrease. Providers who choose not to contract with MMC plans will not receive patients from the plans unless there are insufficient network providers to serve the plan’s</p>

	membership. Absent a negotiated rate, plans must pay non-participating providers at the Medicaid fee-for-service rate.
49. How are we supposed to be paid for service when the patient had similar service (e.g. exam) done by another provider shortly before visiting our office and no treatment history is available to us?	MMC plans may not apply stricter frequency limits than Medicaid fee-for-service imposes. Dental Benefits Managers and MMC plans will have utilization history. Providers should check with these entities to determine how this information may be accessed.
50. What happens if treatment goes over their max, will they be billed Medicaid fees or office fees?	Medically necessary services provided by qualified providers according to the FFS or MMC plan rules will be paid at the Medicaid rate (for FFS patients) or the MMC contract/negotiated rate (for MMC members).
51. If we are an Article 28 facility and have patients with straight Medicaid, do we bill straight Medicaid the 4013 rate, or do we bill a Medicaid managed care insurance? If we bill the 4013 rate - do we need prior approval?	Nothing changes for beneficiaries who are NOT enrolled in a MMC plan. When providers treat patients who are not enrolled in a MMC plan, the provider should bill the State as they do now. In this case, the provider is an FQHC billing under rate code 4013. Non-FQHC <u>clinics</u> will continue to use APG rate codes for FFS clinic billing (for patients not enrolled in a plan).
52. When billing the limited extended coverage for orthodontia treatment, since we wait until the end of the billing period (quarterly, Retention), what 90-day reason would we use?	Providers should choose the appropriate delay reason code that applies to the specific claim. The list is available in the General Billing Guidelines at <a href="https://www.emedny.org/ProviderManuals/AllProviders/index.aspx">https://www.emedny.org/ProviderManuals/AllProviders/index.aspx</a>
53. If we have already billed for 3 Threshold Rate based visits (we are an article 28 FQHC) for Dentures or Root Canals. If services are not completed yet we will need to get PA from Managed Care plan? How will it work on payment already received for the Threshold visits?	If you participate with the patient's MMC plan, you should follow the plan's rules for getting prior approval. If you do not participate with the patient's plan, the 60 day transitional period would apply.
54. We are a FQHC. Will we receive a Medicaid Wrap payment along with the managed care payment to receive our FFS rate?	Yes.
55. During the 60 day transitional care period, will fee for service billing still go through ePACES?	No, during the 60 day transition period, you will need to work with the managed care plan for payment. The 60 days merely allows you to continuing seeing the patient as a non-



	participating provider.
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**Enrollment**

<b>Question</b>	<b>Answer</b>
56. Will every patient receiving dental coverage currently switch to a managed care plan or will some patients remain as fee for service?	As included in MRT 1458, most people over the next 3 years will be enrolling into Medicaid managed care. However, some of your current patients may still be in FFS for dental services after 7/1/12. Swipe the card, check ePACES or call eMedNY.
57. What is an example of a patient that would NOT be enrolled in managed care? Will group home patients, people on SSI and facility residents be enrolled in managed care?	For the time being the DD population will remain in FFS, as will the TBI population – unless they have voluntarily enrolled in MMC. Rather than trying to learn all of the enrollment rules, we suggest providers check for MMC enrollment as described in the previous answer.
58. If we do not have ePACES, how will we know if a patient is managed care?	You will confirm eligibility for Medicaid as you do now, including card swipe or by calling eMedNY.
59. Are patients in the SNPs- Amidacare, VNS Choice and Metroplus - excluded?	No, these plans will also be adding the dental and orthodontia benefits on the same schedule as the “mainstream” plans.
60. If we call or check ePACES for eligibility will it clearly define what dental insurance coverage the patient has?	All MMC plans will cover dental as of 7/2 and orthodontia as of 10/1. Plans must provide, at a minimum, the same coverage available under Medicaid fee-for-service.
61. Will DD population be carved out?	The DD population is currently exempt from enrolling, i.e., they can enroll voluntarily or opt to stay in FFS.

**Miscellaneous**

<b>Question</b>	<b>Answer</b>
62. Does the July transition date apply to Oral Surgeons in NYC? Where can we obtain the contact information for managed care plans?	YES, it will apply. See attached list for the contact info.
63. What would be the process for prior approval for Oral surgeons if the transition applies to them?	If you participate with the patient’s MMC plan, you should follow the plan’s rules for getting prior approval. If you do not participate with the patient’s plan, the 60 day transitional period would apply, and the patient would be switched to a participating provider once the transitional

	period is over or the approved treatment plan is completed, whichever is earlier.
64. Does NY plan to offer coverage to Massachusetts for those members who live on the border?	Plans are allowed to contract with out of state providers to care for NYS residents that live near the border.
65. Does NYS Medicaid provide transportation to and from appointments for enrollees without medical conditions that requires ambulette services? If so would MMC plans be required to do the same?	The transportation benefit is being phased out of the MMC benefit on a county by county basis. By early 2013, the benefit will be billable to Medicaid fee-for-service statewide. Until then, MMC plans that cover non-emergency services must administer the benefit according to the rules established by the Local Social Services District in the county of the patient's residence.
66. How does this work with oral surgery when most of our patients are seen on an emergent basis and there is no time for a prior approval?	Providers should follow the MMC plan's rules regarding notification to the plan for emergency and urgently needed services.
67. What measures are planned by Medicaid and Managed Care to reduce the number of patient no-shows despite appointments made?	You should work with the plans you contract with to assist in educating your patients on the importance of making and keeping appointments.
68. If the patient had Medicare and Medicaid but not MMC, can we see these patients after July 1?	Yes. Dually eligible individuals remain ineligible for enrollment in MMC plans. You may continue to bill them FFS as you do now.
69. Will the managed care organizations be required to function on a capitation basis only?	Reimbursement may be on a capitated basis, a fee-for-service basis, or a combination of the two. The reimbursement methodology and amounts will be negotiated between the plan and the provider as part of the provider contract.
70. Is limited extended coverage available while client has guarantee only coverage?	The limited extended coverage is for clients who have lost ALL eligibility for Medicaid. While in guarantee status, the client is still eligible for plan services, so you will be billing the managed care plan during the guarantee. In order for limited extended coverage to apply, the orthodontic treatment must have begun prior to the guarantee status.
71. If our agency decides not participate with the Medicaid managed care companies, what is our recommendation regarding communication to the patients and their options?	If you do not participate with a member's managed care plan, you should refer the patient to his or her health plan for information on participating providers that the member may switch to.
72. Will this apply to the Southern Tier	No, this will not apply to enrollees of these two

<p>Pediatric and Southern Tier Priority Care plans in Chemung county?</p>	<p>plans. Please note that these plans are being phased out effective 8/31/12.</p>
<p>73. If we apply to get into a managed care plan, how long does it typically take to get approved?</p>	<p>A MCO is required to complete the review of a health care professional's application to participate in a network within 90 days of receipt of a completed application. At that time the provider is to be notified whether he or she is credentialed or whether additional time is necessary because a third party failed to provide the necessary documentation or there were non-routine or unusual circumstances for additional time.</p>