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**LIBERTY DENTAL PLAN
GUIDELINES FOR CHILDREN
UNDER 21 YEARS OF AGE**

SUPPLEMENT TO THE NEW YORK PROVIDER
REFERENCE GUIDE FOR CHILD MEDICAID AND
CHILD HEALTH PLUS MEMBERS

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SECTION 1. MEDICAID PROGRAM GUIDELINES2

- CHILD MEDICAID AND CHILD HEALTH PLUS (CHP)2
- EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT)2
- ESSENTIAL SERVICES.....3
- ORTHODONTIC CARE3
- CONTINUATION OF ORTHODONTIC CARE4
- FOSTER CARE PROGRAM.....4
- SCHOOL-BASED HEALTH DENTAL SERVICES (SBHC-D)5
- SCOPE OF THE SCHOOL-BASED DENTAL HEALTH CENTER (SBHC-D) BENEFITS6

SECTION 2. REFERRAL AND PRIOR AUTHORIZATION GUIDELINES7

- PEDODONTICS7
- ORTHODONTICS7

SECTION 3. FORMS AND RESOURCES8

- ORIENTATION MATERIALS.....8
- FORMS8

SECTION 1. MEDICAID PROGRAM GUIDELINES



The purpose of this document is to offer dental providers supplemental guidance and resources. This information is derived from the Medicaid Dental Policy and Procedure Code Manual and is not intended to serve as a comprehensive guide or a replacement for the Manual. Liberty strongly encourages providers to review and become familiar with the Medicaid Dental Policy and Procedure Code Manual, as it remains the primary source for detailed code descriptors and policy guidance.

CHILD MEDICAID AND CHILD HEALTH PLUS (CHP)

A child is defined as anyone under 21 years of age. To be eligible for Child Health Plus ("CHP"), a child must be under the age of 19. The goal of the CHP program is to improve child health by increasing access to primary and preventive healthcare through a subsidized insurance program. A child eligible for Medicaid is not eligible for CHP. For more information on covered benefits, please refer to the member's applicable Schedule of Benefits available within Liberty's Provider Portal and to the New York State Medicaid Dental Policy and Procedure Code Manual. Recommendations for best practices for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling are outlined in the American Academy of Pediatric Dentistry "[\(AAPD\) Periodicity Table](#)". Medically necessary dental services may exceed the periodicity schedule.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES (EPSDT)

Dental services for children are provided as part of Medicaid's EPSDT program. Services may not be limited to emergency services. Dental screenings by the primary care physician in this context mean, at a minimum, observation of tooth eruption, occlusion patterns, presence of caries, and/or oral infection. The Primary Care Physician ("PCP") is required to refer a child to the dentist by one year of age or soon after the eruption of the first primary tooth for a minimum of 2 dental visits a year. It is mandated that the PCP follow up during well child visits to ensure that all needed preventive and definitive dental services are provided thereafter through the age of twenty (20). A referral to a dental specialist or dentist that provides dental treatment to patients with special needs shall be allowed when a primary care dentist requires a consultation for services by that specialty

provider. For more information, please see EPSDT/CTHP Provider Manual, by visiting the following link:

www.emedny.org/ProviderManuals/EPSDTCTHP/index.aspx.

ESSENTIAL SERVICES

The Medicaid dental benefit is limited and includes only essential services, rather than comprehensive care. The following general guidelines related to treatment of children are used:

- Treatment of deciduous teeth when exfoliation is reasonably imminent is not routinely reimbursable. Claims submitted for the treatment of deciduous cuspids and molars for children 10 years of age or older, or for deciduous incisors in children 5 years of age or older may be pended for professional review. Extraction of deciduous teeth is only reimbursed if injection of a local anesthetic is required.
- Unless a participant in Liberty's BRUSH program, the Caries Risk Assessment (CRA) is not separately reimbursed but should be included in routine treatment planning. For more information on BRUSH, please email: Provider@libertydentalplan.com.
- Placement of sealants for members under 5 or over 15 years of age is not within the scope of the Medicaid Program. 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.
- Crowns and root canal therapy for members under the age of 21 are 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.
- Implant cases in members under age 18 will be considered based on submitted documentation of medical necessity. Although the program does not have a minimum age for approval, the completion of members' skeletal growth and stability of occlusion must be considered for a long-term success of an implant procedure. The maintenance of oral hygiene is imperative to avoid implant failures.
- Services associated with a non-approved procedure are not considered for reimbursement.

ORTHODONTIC CARE

When prior authorization is obtained for orthodontic care for severe physically handicapping malocclusions, the care will be reimbursed for an eligible member for a maximum of three years of active orthodontic care plus one year of retention care. Cleft palate or approved orthognathic surgical cases may be approved for additional treatment time. Treatment not completed within the maximum allowed period must be continued

to completion without additional compensation from the NYS Medicaid program, the member or family. For Medicaid members, 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. For CHP members, treatment must be approved, and active therapy begun (appliances placed and activated) prior to the member's 19th birthday.

With the exception of D8210, D8220 and D8999, orthodontic care is reimbursable only when provided by an orthodontist or an Article 28 facility which has met the qualifications of the DOH and are enrolled with the appropriate specialty code. Orthodontists should only use procedure code D8660 for examinations prior to starting active care.

CONTINUATION OF ORTHODONTIC CARE

Requests to continue comprehensive orthodontic treatment on a member for whom Medicaid Fee-For-Service or another Medicaid managed care plan paid the original comprehensive code (D8070, D8080, or D8090), but who now has coverage administered by Liberty, should be submitted as a new prior authorization request with the following information:

- A copy of the authorization for treatment and the Explanation of Payment ("EOP") and/or Explanation of Benefits ("EOB") statements from the previous carrier.
- Documentation of the number of orthodontic treatment visits that have been rendered to date. This can be done by providing EOB/EOPs for all payments received for all treatment visits, or printout from the previous carrier showing all the visits for which payment has been received.
- The total reimbursement amount for active treatment will not exceed the maximum fees listed in your Provider Agreement.

For completed details on prior authorization guidelines and eligibility requirements, please refer to the New York State Dental Policy and Procedure Code Manual, by visiting www.emedny.org/ProviderManuals/Dental/.

DISCONTINUATION OF TREATMENT

In cases where treatment is discontinued, a "Release from Treatment" form must be provided by the dental office which documents the date and the reason for discontinuing care. The release form must be reviewed and signed by the parent/guardian and member. The "Release from Treatment" form must indicate that all those involved understand future orthodontic treatment will not be covered by Medicaid. A copy must be sent to Liberty.

FOSTER CARE PROGRAM

Children/youth in direct placement foster care in New York City and children/youth placed in foster care in the care of Voluntary Foster Care Agencies ("VFCAs") are enrolled into a managed care plan. Children who enter

foster care placement must receive a dental screening during their initial medical assessment. It is required that foster care children up to age three have their mouths examined at such medical examination and where appropriate, referred for dental care. Foster care children over the age of three (3) are required to see a dentist at minimum, once a year, and must be provided with dental care when needed. Children often enter foster care with no prior dental visits. It is critical that these children receive expedited access to care. Please consider making an extra effort to accommodate these children into your dental practice by ensuring availability of appointments. Foster care parents should never be charged for services that are already covered.

Liberty will ensure there is sufficient network capacity, to meet the timeframe and distance requirements for foster care members for completion of initial dental health assessments, and on-going preventive, and restorative care. Additionally, Liberty will assist with access to dental care issues including facilitation of single case agreements with out of network providers when a participant is placed outside of their managed care plan's service area and/or due to a lack of qualified or available providers in Liberty's network.

Appointment times for foster care members must adhere to the following standards:

- For emergency care: immediately upon presentation at a service delivery site.
- Non-urgent "sick" visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
- Routine non-urgent, preventive appointments, within four (4) weeks of request.
- Specialist referrals (not urgent), within four (4) to six (6) weeks of request.

SCHOOL-BASED HEALTH DENTAL SERVICES (SBHC-D)

Effective no sooner than April 1, 2026, School-Based Health Center ("SBHC") services are included in the Medicaid Managed Care benefit package. School-Based Health Centers that provide SBHC-Dental ("SBHC-D") services on school premises may only serve children and adolescents* who meet the following requirements:

- Resides in the specific school district or in the area served by the board of cooperative educational services; and
- Attends a district school or gets permission from the school's principal to go to a district school to get services at the SBHC.

Members may receive care at the SBHC through the time of their graduation, up to age 21. If the school district offers a preschool program, enrollees as young as preschool age can receive care at the SBHC.

Definitions:

- **SBHC Operators** - licensed Article 28 facilities whose extension clinics (i.e., SBHCs) provide direct service. SBHC operators are responsible for the administration and operation of SBHCs, ensuring that policies and procedures are in accordance with the New York State SBHC Principles and Guidelines Document (LINK HERE: [Principles & Guidelines for School Based Health Centers in New York State](#)).
- **Memorandum of Understanding (MOU) Requirement** - a formal written agreement between the governing authority of the school district and the Article 28 facility that is operating the SBHC which

serves the students within the school. In order for a SBHC-D program to operate in NYS, the Article 28 operators must have an MOU with the school where the clinic will be located. In New York City, the Article 28 operator must have an MOU with the New York City Department of Education.

- **School-Based Dental Health Centers (SBHC-Ds)** - clinics operated by a facility licensed under Article 28 of the Public Health Law that provide dental services within a school building or campus (i.e., Mobile Vans). SBHC-D services may be provided at dental-only SBHC-D sites or may be provided in combination with other health care services at an SBHC site.
- **SBHC-D Services** - include oral health education and diagnostic and preventative treatment, such as comprehensive oral exams, x-rays, oral prophylaxis, fluoride, sealants, restorations, and extractions.

SCOPE OF THE SCHOOL-BASED DENTAL HEALTH CENTER (SBHC-D) BENEFITS

Liberty covers services provided by SBHC-Ds without the need for referral or prior authorization for routine preventive services, such as, prophylaxis, sealants, fillings, fluoride treatments, simple extractions (which includes the elevation and/or forceps removal of an erupted tooth or an exposed root). Dental services that include more extensive care, such as root canals, crowns, dentures, fixed partial dentures, impactions and surgical extractions, and orthodontic treatment follow the prior authorization guidance outlined in the member's Schedule of Benefits.

Responsibilities of SBHC-Ds:

- Work collaboratively with Liberty on quality improvement initiatives, including information sharing to improve health outcomes for children. This includes but is not limited to:
 - Sharing student rosters who are enrolled in the SBHC-D to help determine which students need a comprehensive physical exam and/or other services.
 - Provide member health record information as needed. This specifically includes reports required by the New York State Department of Health ("NYSDOH") or designee for Quality Assurance Reporting Requirements ("QARR").
 - Assistance in improving required quality performance measures.
- Obtain all consents needed to provide services.
- Advance notice to Liberty of any change in directory listing, treating location or provider.
- Adhere to Liberty's credentialing criteria and requirements.

For additional information, please review all resources available through the NYSDOH available here:

[Transition of School Based Health Center Benefit and Population Into Medicaid Managed Care](#)

SECTION 2. REFERRAL AND PRIOR AUTHORIZATION GUIDELINES



PEDODONTICS

Referral Guidelines for the General Dentist - *Members may self-refer* or the general dentist can complete a Liberty Specialty Care Authorization and provide the:

- Patient's name, the Primary Member's name, Liberty identification number, group name and group number;
- Name, address and telephone number of the contracted Liberty network Pediatric Dentist;
- Comments concerning the member's condition.

ORTHODONTICS

Referral Guidelines for the General Dentist - *Members may self-refer* or the general dentist can complete a Liberty Specialty Care Authorization and provide the:

- Patient's name, the Primary Member's name, Liberty identification number, group name and group number;
- Name, address and telephone number of the contracted Liberty network Orthodontist;
- Comments concerning the member's malocclusion.

Guidelines for Orthodontists - To be eligible for orthodontia services, the recipient must meet all the following general requirements:

- Be under twenty-one (21) years of age (Medicaid) or under nineteen (19) years of age (CHP).
- Meet the financial standards for Medicaid or CHP eligibility.
- Exhibit a **SEVERE PHYSICALLY HANDICAPPING MALOCCLUSION**.
- HLD Index score of 26 or higher or one of the automatically qualifying conditions.

HLD Index: <https://www.emedny.org/ProviderManuals/index.aspx>

Diagnostic services including D0330, D0340, D0350, and D0470 will be paid in addition to code D8660.

Frequency limitations will not apply for code D0330 if it is the initial film taken at the orthodontist's office.

SECTION 3. FORMS AND RESOURCES

ORIENTATION MATERIALS

Additional orientation materials can be accessed through the following link:

- Link: [Liberty Secure Documents](#)
- Password: NYOrientation

FORMS AND RESOURCES

The following forms and resources are available to download from Liberty Dental Plan's Resource Library which can be accessed [HERE](#) and selecting "New York" from the dropdown:

- [ADA Caries Risk Assessment Forms](#)
- [Clinical Guidelines for Prescribing Fluoride Supplements for Caries Prevention](#)
- [Handicapping Labio-Lingual Deviation \(HLD\) Index Form](#)
- [AAPD Periodicity Table](#)