Notice Number **2023-2** Rule Number **He-W 566**

1. Agency Name & Address:

Department of Health and Human Services
Division of Medicaid Services
129 Pleasant Street, Brown Building
Concord, NH 03301

2. RSA Authority: **RSA 161:4-a, X**
3. Federal Authority:
4. Type of Action:
   - Adoption
   - Repeal
   - Readoption
   - Readoption w/amendment **X**

5. Short Title: **Dental Services**

6. (a) Summary of what the rule says and of any proposed amendments:

He-W 566 describes the requirements for and services available under the Medicaid fee for service program (FFS) for dental services. The rule describes covered and non-covered services, the prior authorization process, and the provider payment structure.

The Department of Health and Human Services (Department) is proposing to readopt with amendment He-W 566. Amendments to He-W 566 include:

- **Updating various sections of the rule to remove references to interceptive orthodontics and replace them with limited orthodontics. This change was made necessary by the Code Maintenance Committee of the American Dental Association as the coding changed by merging interceptive and limited orthodontics into a single category of treatment, now named limited orthodontic treatment; and**

- **Updating He-W 566.04 on covered services by deleting the requirements of dental services for adults aged 21 and older. The adult dental benefit will now be delivered by a dental organization as part of the Medicaid Care Management Program and the requirements will be added to He-W 506, entitled "Medicaid Care Management".**

6. (b) Brief description of the groups affected:

Groups affected by this rule include all Medicaid recipients and dental service providers under the fee for service program.

6. (c) Specific section or sections of state statute or federal statute or regulation which the rule is intended to implement:

RULE	STATE OR FEDERAL STATUTE OR REGULATION THE RULE IMPLEMENTS
He-W 566.01	42 CFR 440.100, and 42 CFR 440.40
He-W 566.02	42 CFR 440.210, 42 CFR 440.220, and 42 CFR 440.225
He-W 566.03	42 CFR 440.100, 42 CFR 431.107, and 42 CFR 431.108
He-W 566.04	42 CFR 440.100, 42 CFR 440.40, 42 CFR 441.56, 42 CFR 440.225, and 42 CFR 440.50
He-W 566.05	42 CFR 440.225, 42 CFR 440.40, and 42 CFR 441.56
He-W 566.06	42 CFR 440.230
He-W 566.07	42 CFR 440.230

RULE	STATE OR FEDERAL STATUTE OR REGULATION THE RULE IMPLEMENTS
He-W 566.08	42 CFR 455, 42 CFR 456, 42 CFR 447, and 42 CFR 1001
He-W 566.09	42 CFR 433, Subpart D
He-W 566.10	42 CFR Subpart B, and RSA 161:4,VI(a)

7. Contact person for copies and questions including requests to accommodate persons with disabilities:

Name: **Allyson Raadmae**

Title: **Administrator- Administrative Rules Unit**

Address: **Dept. of Health and Human Services**
Administrative Rules Unit
129 Pleasant Street, 2nd Floor
Concord, NH 03301

Phone #: **(603) 271-9604**

Fax#: **(603) 271-5590**

E-mail: **Allyson.E.Raadmae@dhhs.nh.gov**

TTY/TDD Access: Relay NH 1-800-735-2964
or dial 711 (in NH)

The proposed rules may be viewed and downloaded at:
https://www.dhhs.nh.gov/doing-business-dhhs/legal-services/administrative-rules/nh-administrative-rules-public-comment

8. Deadline for submission of materials in writing or, if practicable for the agency, in the electronic format specified: **Thursday, February 9, 2023**

☒ Fax ☒ E-mail ☐ Other format (specify):

9. Public hearing scheduled for:

Date and Time: **Thursday, February 2, 2023 at 1:00pm**

Place: **DHHS Brown Bldg., Auditorium, 129 Pleasant St., Concord, NH**

10. Fiscal Impact Statement (Prepared by Legislative Budget Assistant)

FIS # **22:243** , dated **December 15, 2022**

1. Comparison of the costs of the proposed rule(s) to the existing rule(s):
There is no difference in cost between the proposed rules and the existing rules.

2. Cite the Federal mandate. Identify the impact on state funds:
No federal mandate, no impact on state funds.

3. Cost and benefits of the proposed rule(s):
Any cost or benefit is attributable to Chapter 285, Laws of 2022, which established an adult dental benefit as part of the state Medicaid program.

A. To State general or State special funds:
None.

B. To State citizens and political subdivisions:
None.

C. To independently owned businesses:
None.

11. Statement Relative to Part I, Article 28-a of the N.H. Constitution:

The proposed rule modifies an existing program or responsibility, but does not mandate any fees, duties or expenditures on the political subdivisions of the state, and therefore does not violate Part I, Article 28-a of the N.H. Constitution.

Readopt with amendment He-W 566, effective 12-7-19 (Document #12937), to read as follows:

PART He-W 566 DENTAL SERVICES

He-W 566.01 Definitions.

(a) "By report" means a written description of the service provided and the medical necessity of same as required by the department to be submitted with certain claims for payment of such claims.

(b) "Comprehensive orthodontic treatment" means diagnosis, long-term treatment, periodic evaluations, and retention, leading to improvement of a recipient's malocclusion.

(c) "Deciduous teeth", also known as primary teeth, means the 20 teeth that erupt first and are normally shed and replaced by secondary teeth.

(d) "Department" means the New Hampshire department of health and human services.

(e) "Destruction of tissue" means demonstrable, traumatic alteration of soft or hard tissue architecture with history of treatment of pain.

(f) "Diagnostic model" means a model or representation that demonstrates all erupted teeth, the gingival tissue surrounding the anterior and posterior arches, and the true occlusal relationships of the teeth and tissues.

(g) "Differential diagnosis" means a condition or disorder consistent with and reasonably thought to be the cause of the history, signs, and symptoms presented by the recipient which is determined by a process that differentiates it from other conditions or disorders with similar signs or symptoms.

(h) "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services" means a program, pursuant to 42 CFR 440.40, designed to provide preventative health care, diagnostic services, and early detection and treatment of disease or abnormalities to Title XIX eligible individuals under age 21.

~~(i) "Interceptive orthodontic treatment" means an intervention in the initial stages of a developing problem related to the dentition, to lessen severity of the malformation and to eliminate its cause.~~

(~~i~~j) "Limited orthodontic treatment" means orthodontic treatment with a limited objective or scale of treatment and not involving the entire dentition.

(~~j~~k) "Malocclusion" means improper alignment of the biting or chewing surfaces of upper and lower teeth that results from a deviation of the alignment of the teeth from the ideal alignment.

(~~k~~l) "Medicaid" means the Title XIX and Title XXI programs administered by the department which makes medical assistance available to eligible individuals.

(~~l~~m) "Medically necessary" means:

(1) For individuals under age 21, reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service; and

(2) For individuals age 21 and over, health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted

standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

a. Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;

b. Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;

c. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and

d. Not experimental, investigative, cosmetic, or duplicative in nature.

(~~m~~m) "Palliative treatment" means minor treatment to reduce the pain of a disease, illness, or injury of the tooth or teeth excluding non-treatment activities such as writing a prescription, dispensing a drug or medication, or telephone consultation with or about a recipient.

(~~n~~n) "Radiograph" means an image or picture produced by exposure to ionizing radiation of a radiation-sensitive film, phosphorous plate, emulsion, or digital sensor.

(~~o~~o) "Recipient" means any individual who is eligible for and receiving medical assistance under the medicaid program.

(~~p~~p) "Severe handicapping malocclusion" means a malocclusion resulting from severe skeletal discrepancies that can be objectively documented as causing the following:

(1) Tissue injury;

(2) Significantly impaired speech, mastication, breathing or swallowing; or

(3) Severe psychological trauma or severe antisocial behavior.

(~~q~~q) "Title XIX" means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

(~~r~~r) "Title XXI" means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

He-W 566.02 Recipient Eligibility. All Title XIX recipients shall be eligible to receive dental services, in accordance with He-W 566.

He-W 566.03 Provider Participation. Each participating dental provider shall:

(a) Hold an active license to practice dentistry in the state in which he or she practices;

(b) Be a New Hampshire enrolled Title XIX provider; and

(c) Request and obtain prior authorization from the department, in accordance with He-W 566.07.

He-W 566.04 Covered Services.

(a) The following dental services shall be covered for recipients who are under 21 years of age:

(1) Prophylaxis, no more frequently than every 150 days;

(2) Restorative treatment;

(3) Periodic examinations, no more frequently than every 150 days, unless they are medically necessary to diagnose an illness or condition;

(4) Vital pulpotomy, which consists of removal of diseased or involved pulp in an effort to retain the remaining pulp in a healthy, vital condition;

(5) Extractions of symptomatic teeth associated with diagnosed pathology, such as tumor, cyst, or infection, except third molars as described in (7) below;

(6) Extractions of asymptomatic teeth, except third molars as described in (7) below, subject to prior authorization in accordance with He-W 566.07, as follows:

a. When associated with diagnosed pathology, such as tumor, cyst, or infection; or

b. When extraction is part of an orthodontic treatment plan that has been approved through prior authorization by the department in accordance with He-W 566.07;

(7) Third molar extraction, subject to prior authorization in accordance with He-W 566.07;

(8) General anesthesia when medically necessary and documented in the recipient's dental records;

(9) Nitrous oxide analgesia and intravenous therapy sedation;

(10) Comprehensive orthodontic treatment for severe handicapping malocclusion in accordance with He-W 566.05(a), subject to prior authorization in accordance with He-W 566.07;

(11) Limited~~Interceptive~~ orthodontic treatment in accordance with He-W 566.05(b), subject to prior authorization in accordance with He-W 566.07;

(12) Space maintainers when medically necessary to replace a prematurely lost deciduous or permanent molar or bicuspid;

(13) Limited orthodontic treatment in accordance with He-W 566.05(c);

(14) Radiographs as follows:

a. Complete series or panographic survey, once every 5 years;

b. Bitewings every 12 months if medically necessary; and

c. All types of dental radiographs regardless of limits in a. and b. above, as may be required to complete a differential diagnosis;

(15) Palliative treatment when the claim is submitted in accordance with He-W 566.10(f);

(16) Removable prosthetic replacement of permanent teeth subject to prior authorization in accordance with He-W 566.07;

(17) Topical fluoride treatment applied twice per year until age 21;

(18) If moderate or high risk of caries is documented, 2 applications of silver diamine per tooth, provided that no more than 18 total silver diamine treatments shall be administered per year and no application of silver diamine shall be administered after the recipient reaches the age of 21;

(19) Endodontia, including root canal therapy, excluding third molars, when the claim is accompanied by a radiograph, and the endodontia treatment is deemed complete when all radiographs demonstrate that the canals are completely filled to the apex of the root(s) of the tooth in accordance with He-W 566.10(e);

(20) Crowns;

(21) Periodontal treatment limited to prophylaxis, scaling, and root ~~planing~~planning;

(22) Surgical periodontal treatment subject to prior authorization in accordance with He-W 566.07;

(23) Sealants for permanent and deciduous molars every 5 years, until age 21;

(24) Diagnostic and preventive dental services, with the exception of orthodontic treatment as allowed in (b) below, available for EPSDT-eligible children in accordance with He-W 546.05; and

(25) Other services determined by the department to be medically necessary, in accordance with He-W 546.06.

(b) Orthodontic treatment for malocclusions that do not meet the criteria set forth in He-W 566.05(b) shall be considered for orthodontic treatment under the EPSDT prior authorization for coverage based on medical necessity provisions at He-W 546 when documentation of the following is submitted to the department:

(1) Principal diagnosis;

(2) Prognosis with and without treatment;

(3) Date of onset of the illness or condition and etiology, if known;

(4) Clinical significance or functional impairment or pathology caused by the illness or condition resulting from the malocclusion;

(5) Demonstration of evidence of the degree to which the malocclusion contributes to the illness or condition;

(6) Specific types of services to be rendered by each discipline associated with the total treatment plan;

(7) Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals;

(8) Explanation of any existing conditions that are likely to limit efficacy of treatment;

(9) Extent to which health care services have been previously provided to address the illness or condition and summary of results demonstrated by prior care;

(10) Orthodontic records as described in He-W 566.05(g)(1), (2) and (4); and

(11) Any additional documentation in accordance with He-W 546.06(b) or any other documentation available which might assist in making a determination of medical necessity of the proposed orthodontic treatment.

(c) The documentation submitted in accordance with (b) above shall be completed by health professionals who are sufficiently trained and duly licensed to diagnose and treat the illness or condition arising from the malocclusion and creating the medical necessity for treatment.

(d) The documentation described in (b) and (c) above shall be submitted to the department by the medicaid enrolled provider who will complete the orthodontic treatment along with a request for prior authorization in accordance with He-W 546.06.

(e) The following dental services shall be covered for recipients 21 years of age or over ~~for relief of acute pain or elimination of acute infection or diagnosed pathology~~:

(1) Diagnostic, preventive, limited periodontal, restorative, and oral surgery services;

(2) Removable partial and full dentures that shall be limited to adults who participate in Section 1915(c) of the Social Security Act waivers and nursing facility residents.

~~(1) Palliative treatment when the claim is submitted in accordance with He-W 566.10(f);~~

~~(2) Extraction of the causative tooth or teeth and biopsy of the tooth or teeth;~~

~~(3) Treatment of severe trauma, when a determination is made by the attending clinician using standard medical parameters for emergency conditions, which shall include, but not be limited to:~~

~~a. Hemorrhage;~~

~~b. Laceration requiring suturing;~~

~~c. Abrasion requiring debridement; or~~

~~d. Bone fracture requiring reduction; and~~

~~(4) Radiographs and examinations as necessary to assess conditions described in (1)-(3) above.~~

He-W 566.05 Orthodontic Treatment.

(a) Comprehensive orthodontic treatment shall be covered for recipients under 21 years of age who demonstrate severe handicapping malocclusion, which limits function and if left untreated would result in damage to the dental structures or surrounding tissue, due to one or more of the following conditions:

(1) Crowding of teeth greater than 12 mm in a single arch;

(2) Deep impinging overbite with destruction of tissue;

(3) Crossbite of anterior teeth with destruction of tissue;

(4) Overjet greater than 9 mm;

(5) Reverse overjet greater than 3.5 mm; or

(6) Severe traumatic deviations demonstrated by gross pathology.

(b) Limited ~~Interceptive~~ orthodontic treatment shall be covered for recipients under 21 years of age, by assisting the dentition growth process through preventive or corrective therapeutic measures, who have at least one of the following conditions:

(1) Constricted palate;

(2) Deep impinging overbite with demonstration of destruction of tissue;

(3) Anterior crossbite;

(4) Teeth in traumatic occlusion;

(5) Partially impacted permanent teeth; or

(6~~4~~) Dentition exhibiting results of harmful habits.

(c) Limited orthodontic treatment shall be covered for recipients under 21 years of age, by report, and no more than 4 units, of any combination of upper and lower arches, ~~once per arch~~ per recipient per lifetime.

(d) Comprehensive and limited~~interceptive~~ orthodontic treatment shall:

(1) Each be covered once per recipient per lifetime; and

(2) Require prior authorization in accordance with He-W 566.07.

(e) Sealants shall be present on all permanent molars prior to the provider requesting prior authorization in (d)(2) above.

(f) Any dental provider who undertakes orthodontic treatment for children with severe handicapping malocclusions shall be qualified by training and experience in accordance with Den 302.04.

(g) In addition to the information required at He-W 566.07, prior authorization requests for comprehensive and ~~interceptive~~ limited orthodontic treatment shall include the following:

(1) A treatment plan, which shall address and include the following:

a. Diagnosis and explanation describing the nature of the severe handicapping malocclusion or functional limitation associated with the malocclusion with sufficient detail and documentation to support and demonstrate the existence of conditions described in (a)-(b) above or He-W 546.05;

b. Justification for early treatment if the request is for comprehensive treatment and deciduous teeth are present or not all of the permanent teeth have erupted;

c. Name of the referring dentist;

d. Description of the chief complaint expressed by the referring dentist or the recipient or legal representative;

e. Specific treatment objectives;

f. Description of the plan for comprehensive oral care during orthodontic treatment;

g. Signed statement from the provider attesting that:

1. The recipient has received an oral examination and was found to be free of untreated oral disease;

2. The recipient demonstrates oral hygiene habits consistent with being able to prevent inflammation and dental decay during orthodontic treatment; and

3. Sealants are in place on all of the recipient's unrestored erupted molars; and

h. Signed statement from the recipient or legal representative acknowledging the recipient's understanding and acceptance:

1. Of the provider's treatment plan including, but not limited to, the recipient's willingness to adhere to an oral hygiene regimen necessary to prevent inflammation and decay, to attend any scheduled appointments, and to properly wear and maintain the appliance;

2. Of the provider's right to discontinue treatment for non-compliance, including, but not limited to, the recipient's failure to adhere to oral hygiene expectations, missed appointments, and failure to properly wear or maintain appliances;

3. That the Title XIX program will not pay for the cost of orthodontic treatment beyond the recipient's 21st birthday; and

4. That the Title XIX program will not pay for the cost of orthodontic treatment more than once per recipient per lifetime if treatment is terminated due to non-compliance with the treatment plan as documented by the provider;

(2) Diagnostic model taken within 30 days of submitting the prior authorization request;

(3) Treatment cost estimate;

(4) Except as allowed by (h) below, radiographs that are current and of adequate quality to allow for an accurate diagnosis of the malocclusion; and

(5) Assurance that the requested treatment is the least restrictive, most cost-effective treatment for the malocclusion.

(h) When requesting limited~~interceptive~~ treatment, photographs, and/or scans may be submitted in lieu of radiographs, provided the photographs clearly demonstrate the criteria being considered for approval.

(i) Banding shall occur within 60 days of the receipt of the prior authorization approval.

(j) Comprehensive and limited orthodontic treatment shall be covered only if the recipient adheres to the treatment plan of care specified at (g)(1) above.

(k) Treatment may be terminated by the provider for non-compliance, including, but not limited to, the recipient's failure to adhere to oral hygiene expectations, missed appointments, and failure to properly wear or maintain appliances.

(l) Providers shall supply the department with treatment progress reports at the following intervals:

(1) A progress report immediately following the 12th month of treatment, including a description of recipient compliance with the provider's treatment plan and a report of objectives achieved to date;

(2) A final treatment report, including diagnostic models or post treatment photographs of the dentition in centric relation from center, right and left sides, submitted at the conclusion of treatment which demonstrate that the treatment goals have been met; and

(3) Immediate report of any patterns of non-compliance, if applicable.

He-W 566.06 Non-Covered Services. Non-covered services shall include:

(a) A dental procedure, which is attempted but cannot be completed;

(b) Behavior management or the administration of psychotropic medication to modify the recipient's behavior in the dental office;

(c) Experimental, investigational, or cosmetic dental procedures;

(d) Dental and orthodontic treatment or surgery for the purpose of preserving or improving appearance, except when required for the prompt repair of accidental injury;

(e) Services that have not been proven to be safe or effective, as documented in dental peer review literature;

(f) Fixed prostheses of more than one unit;

(g) Implants and procedures associated with implants such as bone grafting;

(h) Dental services rendered in locations other than the dental office, such as in outpatient hospital settings or ambulatory surgical centers, when such services could be performed in a dentist's office and there is no medical need for the use of an acute care, outpatient hospital, or ambulatory facility;

(i) Orthodontic treatment for recipients who have failed to comply with a prescribed treatment plan that has been approved through prior authorization by the department, including non-compliance with appointments, hygiene, or care of appliances, with such failure documented by the provider;

~~(j) Periodic examinations for recipients age 21 or over;~~

(~~k~~j) Services that are not dental in nature;

(~~l~~k) Services that are more costly than other services but are expected to provide the recipient with the same functional outcome;

(~~m~~l) Replacement or repair of dental appliances required as a result of recipient neglect, wrongful disposition, intentional misuse or abuse;

(~~n~~m) Extractions of asymptomatic teeth and third molars, unless prior authorized in accordance with He-W 566.07;

(~~o~~n) Periodontal treatment consisting of subgingival placement of biological materials or chemotherapeutic agents;

(~~p~~o) Periodontal surgery, unless prior authorized in accordance with He-W 566.07;

(~~q~~p) The portion of the orthodontic treatment plan carried out after the recipient reaches 21 years of age;

(~~r~~q) Any treatment, such as extractions, radiographs, examinations, and other services, that are ancillary to an orthodontic treatment plan that has not been prior authorized for medicaid coverage;

(~~s~~r) Dental records, including casts and radiographs, when such records do not meet the criteria set forth in He-W 566.05(a)-(b) above or He-W 546.05; and

(ts) Endodontics, including root canal therapy, that has not been deemed complete in accordance with He-W 566.04(a)(18) and He-W 566.10(e).

He-W 566.07 Prior Authorization.

(a) The following dental services and procedures, as described in He-W 566.04, shall require prior authorization from the department:

(1) Comprehensive and ~~interceptive~~limited orthodontic treatment;

(2) Dental orthotic device;

(3) Surgical periodontal treatment;

(4) Extraction of asymptomatic teeth and third molars; and

(5) Removable prosthesis.

(b) Procedures for prior authorization shall be as follows:

(1) The prior authorization shall be for the item or treatment requested and be obtained prior to providing the item or treatment;

(2) Notwithstanding (1) above, for extractions that warrant immediate action, both the prior authorization request and the claim for payment shall be submitted to the address in (4) below after the extraction is performed;

(3) The recipient shall have the primary responsibility for obtaining prior authorization and may do this with the assistance of the provider, who requests authorization on behalf of the recipient; and

(4) Requests for dental prior authorizations shall be addressed to:

New Hampshire Department of Health and Human Services
Office of Medicaid Business and Policy
Dental Director's Office
Attn: Dental Consultant
129 Pleasant Street
Concord, NH 03301

(c) Requests for prior authorization shall include sufficient, current medical information to enable the department to evaluate the request.

(d) Prior authorization requests for services in (a) above, shall include:

(1) An explanation describing the illness, special care, or specific condition, to enable the department to understand the physical and/or emotional problem of the recipient and the specified goal for which the item or treatment is being requested;

(2) Assurance that the required treatment is the least restrictive, most cost-effective alternative;

(3) Cost of the treatment, if known;

(4) Diagnosis;

(5) Expected outcome and recommended timetable of the prescribed item or treatment;

(6) Name and address of the intended provider;

(7) Name and address of person or agency making the request;

(8) Radiographs;

(9) Periodontal charting when surgical periodontal treatment is requested; and

(10) Recipient name, address, date of birth, and medicaid identification number (MID).

(e) In addition to (d) above, prior authorization requests for the extraction of third molars and asymptomatic teeth shall also include an explanation describing the specific conditions or illness that requires tooth removal and a radiograph supporting the rationale for removal, and shall include the diagnosed pathology, if present, for each tooth requested.

(f) Prior authorization requests for comprehensive and ~~interceptive~~ limited orthodontic treatment shall include, in addition to the information specified in (c) and (d) above, information specified in He-W 566.05(g).

(g) Prior authorizations shall be approved by the department upon determination that the treatment requested is appropriate, cost effective and supported by the documentation submitted in accordance with (b) through (f) above.

(h) If the department approves the prior authorization request, the state's fiscal agent shall send written notification of the approval to the provider.

(i) Prior authorization requests for comprehensive and ~~interceptive~~ limited orthodontic treatment that do not have enough information as required in accordance with He-W 566.05(g) and (c) through (f) above for an approval or denial decision shall be returned to the provider.

(j) All prior authorizations approved shall be provider-specific and shall be non-transferable between providers.

(k) Prior authorization requests for services and procedures specified in (a)(2)-(5) above that do not have enough information as required in accordance with (c) through (e) above for an approval or denial decision shall be returned to the provider.

(l) Providers shall be responsible for determining that the recipient is medicaid eligible on the date of service.

(m) If the department denies the prior authorization request, the department shall forward a notice of denial to the recipient and the provider on the department's Form 272a, "Medical Assistance Program Denial for Prior Authorized Services," which includes the following information:

(1) The reason for, and legal basis of, the denial; and

(2) Information that a fair hearing on the denial may be requested within 30 calendar days of the date on the notice of the denial, in accordance with He-C 200.

(n) Decisions made by the department in accordance with (g)-(i) and (k) above shall not be superseded by the treating or consultative health care professional's prescription, orders, or recommendations.

He-W 566.08 Utilization Review and Control.

(a) The department's program integrity unit shall monitor utilization of dental services to identify, prevent, and correct potential occurrences of fraud, waste, and abuse in accordance with 42 CFR 455, 42 CFR 456, 42 CFR 1001, and He-W 520.

(b) The department shall recoup state and federal medicaid payments as permitted by 42 CFR 455, 42 CFR 447, and 42 CFR 456 for a provider's failure to maintain supporting records in accordance with He-W 520 and He-W 566.

He-W 566.09 Third Party Liability. All third party obligations shall be exhausted before the Title XIX program shall be billed, in accordance with 42 CFR 433.139, except that if the recipient is under age 21 and is an EPSDT participant or has other medical insurance provided by an absent parent, the Title XIX program shall pay the provider for the service rendered and pursue reimbursement from the other medical insurance.

He-W 566.10 Payment for Services.

(a) Payment for dental services shall be made in accordance with rates established by the department in accordance with RSA 161:4, VI(a).

(b) Dental providers shall submit claims for payment to the department's fiscal agent.

(c) Pursuant to He-W 566.07(b)(2), for extractions that warrant immediate action, both the prior authorization request and the claim for payment shall be submitted to the address in He-W 566.07(b)(4).

(d) Dental providers shall maintain supporting records, in accordance with He-W 520 and this part.

(e) Payments for endodontic treatments, including root canal treatment, shall be made only when the provider submits a radiograph that demonstrates that the endodontic therapy was successful, effective, and complete when completely filled to the apex of the root(s) of the tooth.

(f) Payment for palliative treatments shall be made only when the provider submits documentation by report that demonstrates that the treatment was completed and the services provided were consistent with palliative treatment as defined in He-W 566.01(n).

(g) Payment for comprehensive orthodontic treatment shall be inclusive of, but not limited to:

(1) All examinations associated with the orthodontic treatment including periodic and emergency examinations;

(2) All periodic adjustments associated with the orthodontic treatment;

(3) All radiographs, diagnostic models, images, and other records associated with the orthodontic treatment;

(4) Space maintenance, when performed by the orthodontic provider within 2 years of the banding;

(5) Appliances as applied;

(6) Application and removal of appliances;

(7) Replacement and repair of brackets, bands, and arch wires;

(8) Retainers and follow-up examinations;

(9) Treatment ancillary to the orthodontia, including, but not limited to, separators and radiographs;

(10) Orthodontically related palliative treatment; and

(11) Closing records.

(h) Payment for ~~interceptive~~ limited orthodontic treatment shall be inclusive of, but not limited to:

(1) All examinations associated with the orthodontic treatment including periodic and emergency examinations;

(2) All periodic adjustments associated with the orthodontic treatment;

(3) All radiographs, diagnostic models, images, and other records associated with the orthodontic treatment;

(4) Space maintenance, if applicable;

(5) Appliances as applied;

(6) Application and removal of appliances;

(7) Replacement and repair of brackets, bands, and arch wires;

(8) Retainers and follow-up examinations, if applicable;

(9) Treatment ancillary to the orthodontia, including but not limited to separators and radiographs;

(10) Orthodontically related palliative treatment; and

(11) Closing records.

(i) Payments for comprehensive orthodontic treatment for services prior authorized shall be made to the provider in 3 equal installments upon the department's receipt of an orthodontic claim and as follows:

(1) A payment shall be made following the application of appliances;

(2) A payment shall be made following the completion of the 12th month of treatment and the submission of a progress report as described in He-W 566.05(l)(1); and

(3) A payment shall be made following case completion and the submission of the final treatment report and photographs as described in He-W 566.05(l)(2).

(j) In the event of termination, provider payment for comprehensive treatment shall be prorated as follows:

(1) If the appliances have been applied and the recipient is terminated or transferred before completing 12 months of treatment, the provider shall receive payment in accordance with (i)(1) above plus a payment equal to the reimbursement rate for each periodic adjustment the recipient received; and

(2) If the recipient has completed 12 months of treatment and is terminated prior to case completion, the provider shall receive payment in accordance with (i)(1)-(2) above plus a payment equal to the reimbursement rate for each periodic adjustment the recipient received following the 12th month of treatment, up to 10 adjustments.

(k) If treatment of the recipient is transferred to another provider, the new provider shall:

(1) Request prior authorization for treatment in accordance with He-W 566.07; and

(2) Receive payment based on the terms of the treatment plan that has been approved through prior authorization by the department in accordance with He-W 566.07.

(l) Prior to terminating orthodontic treatment of a recipient, the provider shall remove the appliances and provide retention.

APPENDIX

RULE	STATE OR FEDERAL STATUTE OR REGULATION THE RULE IMPLEMENTS
He-W 566.01	42 CFR 440.100, and 42 CFR 440.40
He-W 566.02	42 CFR 440.210, 42 CFR 440.220, and 42 CFR 440.225
He-W 566.03	42 CFR 440.100, 42 CFR 431.107, and 42 CFR 431.108
He-W 566.04	42 CFR 440.100, 42 CFR 440.40, 42 CFR 441.56, 42 CFR 440.225, and 42 CFR 440.50
He-W 566.05	42 CFR 440.225, 42 CFR 440.40, and 42 CFR 441.56
He-W 566.06	42 CFR 440.230
He-W 566.07	42 CFR 440.230
He-W 566.08	42 CFR 455, 42 CFR 456, 42 CFR 447, and 42 CFR 1001
He-W 566.09	42 CFR 433, Subpart D
He-W 566.10	42 CFR Subpart B, and RSA 161:4,VI(a)