NEW YORK STATE | Office of the Medicaid Inspector General

OMIG AUDIT PROTOCOL
Dental
Revised 08/05/2025

(For Service Dates 10/01/2012 through 07/02/2025)

Audit protocols assist the Medicaid provider community in developing programs to evaluate compliance with Medicaid requirements under federal and state statutory and regulatory law. Audit protocols are intended solely as guidance in this effort. This guidance does not constitute rulemaking by the New York State Office of the Medicaid Inspector General (OMIG) and may not be relied on to create a substantive or procedural right or benefit enforceable, at law or in equity, by any person. Furthermore, nothing in the audit protocols alters any statutory or regulatory requirement and the absence of any statutory or regulatory requirement from a protocol does not preclude OMIG from enforcing the requirement. In the event of a conflict between statements in the protocols and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.

A Medicaid provider's legal obligations are determined by the applicable federal and state statutory and regulatory law. Audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and, therefore, are not a substitute for a review of the statutory and regulatory law. OMIG cannot provide individual advice or counseling, whether medical, legal, or otherwise. If you are seeking specific advice or counseling, you should contact an attorney, a licensed practitioner or professional, a social services agency representative, or an organization in your local community.

Audit protocols are applied to a specific provider type or category of service in the course of an audit and involve OMIG's application of articulated Medicaid agency policy and the exercise of agency discretion. Audit protocols are used as a guide in the course of an audit to evaluate a provider's compliance with Medicaid requirements and to determine the propriety of Medicaid expended funds. In this effort, OMIG will review and consider any relevant contemporaneous documentation maintained and available in the provider's records to substantiate a claim.

OMIG, consistent with state and federal law, can pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program. Furthermore, audit protocols do not limit or diminish OMIG's authority to recover improperly expended Medicaid funds and OMIG may amend audit protocols as necessary to address identified issues of non-compliance. Additional reasons for amending protocols include, but are not limited to, responding to a hearing decision, litigation decision, or statutory or regulatory change.

OMIG AUDIT PROTOCOL
Dental
(For Service Dates 10/01/2012 through 07/02/2025)

1.	**Missing Service Documentation**
OMIG Audit Criteria	If the provider is missing documentation for a service provided, then the amount paid for the service will be disallowed.
Regulatory References	18 NYCRR § 504.3(a)-(i) 18 NYCRR § 540.7(a) 18 NYCRR § 540.7(b) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II **For Services 11/01/16 and After:** NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2016 through 2025-1, Section II

2.	**Service Documentation Does Not Meet Required Standards**
OMIG Audit Criteria	If the provider has inaccurate, inadequate, or illegible supporting documentation for a service provided, then the amount paid for the service will be disallowed.
Regulatory References	18 NYCRR § 504.3(a)-(i) 18 NYCRR § 540.7(a) 18 NYCRR § 540.7(b) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section II NYS DOH Medicaid Update, May 2006, Vol. 21, No. 5

3.	**Dental Claim Information / Data Does Not Meet Required Standards**
OMIG Audit Criteria	If any required dental forms or information on dental forms submitted by a provider for reimbursement is incorrect, missing, incomplete and/or illegible, the amount paid for the service will be disallowed.
Regulatory References	18 NYCRR § 504.3(f)-(i) 18 NYCRR § 540.7(a) 18 NYCRR § 540.7(b) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section II NYS DOH Medicaid Update, November 2006, Vol. 21, No. 12 Dental Provider Communication: Billing and Payment Update for Dental Services March 25, 2010 **For Services 09/04/12 and After:** Dental Provider Communication: Changes in Fee-for-Service (FFS) Dental Place of Service (POS) Payment Methodology and Prior Approval (PA), September 4, 2012

4.	Service Provided Without Documentation of Medical Necessity
OMIG Audit Criteria	If no evidence of medical necessity is documented and provided, the amount paid for the service will be disallowed.
Regulatory References	18 NYCRR § 504.3(a)-(i) 18 NYCRR § 506.2(a) 18 NYCRR § 540.7(a)(10)(xi) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Sections II and V NYS DOH Medicaid Update, May 2006, Vol. 21, No. 5

5.	Duplicate Billing, Frequency Exceeded and/or Conflicting Service
OMIG Audit Criteria	If the service provided was included in the reimbursement of the same or another billed and paid service, or if it is included in the follow-up care of another billed and paid service, or if a service was previously paid to the same or related provider, then the overpayment will be disallowed. Conflicting services will also be disallowed.
Regulatory References	18 NYCRR § 504.3(i) 18 NYCRR § 518.1(c) 18 NYCRR § 518.3(a)-(b) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Sections II, III, and V

6.	Overpayment; Maximum Fee Exceeded
OMIG Audit Criteria	If the payment received exceeds the maximum fee identified by Medicaid for the service provided, then the overpaid amount will be disallowed. If a payment from a Managed Care Organization (MCO) to a provider exceeds the amount allowed in the contract between the MCO and the provider, then the overpaid amount will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) 18 NYCRR § 518.1(c) 18 NYCRR § 518.3(a)-(b) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Sections II, III, and V

7.	**Incorrect Procedure Code**
OMIG Audit Criteria	If the provider utilized an incorrect procedure code, the difference between the incorrect procedure code and correct procedure code will be disallowed.
Regulatory References	18 NYCRR § 504.3(h) and (i) 18 NYCRR § 518.1(c) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section II and V Dental Provider Communication: Billing and Payment Update for Dental Services March 25, 2010

8.	**No Recipient Treatment Visits Documented During Paid Orthodontic Treatment Quarter**
OMIG Audit Criteria	If the recipient treatment record submitted reflects that no treatment visits occurred during the paid orthodontic treatment quarter, the amount paid for the service will be disallowed.
Regulatory References	18 NYCRR § 504.3(a)-(i) 18 NYCRR § 506.4 NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section V

9.	**Comprehensive Orthodontic Treatment was Billed and Paid Prior to the Placement of All Component Parts and Date Active Treatment Initiated**
OMIG Audit Criteria	If Comprehensive Orthodontic Treatment is billed and paid prior to the placement of all component parts and active treatment being initiated, the amount paid will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) 18 NYCRR § 506.4(a) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section V

10.	**Diagnostic Imaging Fails to Comply with Program Requirements**
OMIG Audit Criteria	Dental diagnostic imaging should be clear and allow for diagnostic assessment. If the submitted diagnostic imaging fails to comply with program requirements, the service will be disallowed. In addition, any amount paid for services that were dependent on that image to substantiate that service will also be disallowed.
Regulatory References	18 NYCRR § 504.3(a)-(i) 18 NYCRR § 505.17 18 NYCRR § 540.7(a)(10)(viii) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section II

11.	**Billed and/or Reimbursed Service Not in Conformance with Prior Approval / Authorization Requirements**
OMIG Audit Criteria	If a reimbursed service is not in conformance with prior approval requirements, then the amount reimbursed for that service will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) 18 NYCRR § 506.3(b) 18 NYCRR § 513.0(c) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Sections I and II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section III

12.	**Provider Requested Payment from Recipient in Excess of Payment Received from Medicaid**
OMIG Audit Criteria	If the provider requests payment over and above the amount received as payment in full for care from Medicaid, the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(c) and (i) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Sections I and II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section III NYS DOH Medicaid Update, February 2014, Vol. 30, No. 2

13.	**Provider / Group Billed Medicaid for a Service that the Provider / Group Provides the General Public at a Reduced Rate or Free of Charge**
OMIG Audit Criteria	If the Provider / Group billed Medicaid for a service that the Provider / Group provided to the general public at a reduced rate or free of charge, the amount paid for the service will be disallowed.
Regulatory References	18 NYCRR § 504.3(c) and (i) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section I NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section III

14.	**Anesthesia Not Billed Correctly**
OMIG Audit Criteria	If the anesthesia was not calculated or billed correctly, the amount paid for the service will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) 18 NYCRR § 533.5(a) 18 NYCRR § 535.4(a) 18 NYCRR § 535.4(b)(1) 18 NYCRR § 535.5 NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section V

15.	**Restricted Recipient. Service Not Ordered, Rendered and/or Referred by Primary Dentist**
OMIG Audit Criteria	If a claim is paid for a restricted recipient and the servicing provider is not the primary dentist that the recipient is restricted to, or the servicing provider is not a provider the restricted recipient was referred to by the primary dentist, the amount paid for the claim will be disallowed.
Regulatory References	18 NYCRR § 360-6.4 18 NYCRR § 504.3(e) and (i) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section I, II and V NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section III

16.	Dental Treatment / Service Provided is Not a Covered and/or Essential Service
OMIG Audit Criteria	If the paid service is beyond the scope of the NYS Dental Medicaid program and is not a covered and/or essential service, the amount paid will be disallowed. If payment is for a service beyond the provisions of the Managed Care Organization's contract with the provider, the overage amount will be disallowed.
Regulatory References	18 NYCRR § 504.3(i) 18 NYCRR § 506.2 18 NYCRR § 506.4 NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section II

17.	Dental Services Billed to Medicaid for Which a Third Party is Liable
OMIG Audit Criteria	If there is a private insurance / third party payor that the provider failed to utilize first, the amount of the claim will be disallowed.
Regulatory References	18 NYCRR § 360-7.2 18 NYCRR § 504.3(c), (h), and (i) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Sections I and II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section III

18.	Billed Item Included in a Facility's Rate
OMIG Audit Criteria	Payment will not be made for services covered by a facility or organization when the cost of those services is included in the facility or organization rate. It is the provider's responsibility to determine if the recipient is a resident of a long-term care / rate-based facility. If the dental service was submitted by a provider directly as a fee-for-service (FFS) claim, and the recipient is a resident of a rate-based facility, the amount of the claim will be disallowed.
Regulatory References	18 NYCRR § 504.3(c), (h), and (i) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section I NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Sections III and V

19.	**Failure to Enroll as a Group Practice and/or Failure to be Added as a Member of a Group Practice**
OMIG Audit Criteria	When two or more providers practice their profession at a common location, they must enroll as a group practice or the claim will be disallowed; if a Provider has not been added as a member of an enrolled group practice (with no application in process) the amount paid for the claim will be disallowed. Managed Care Organization contracted dental providers must be registered as dental providers with the NYS Medicaid Program. If a servicing provider is not registered with Medicaid, the procedures billed that are shown to be performed by said provider will be disallowed.
Regulatory References	18 NYCRR § 502.2(f) 18 NYCRR § 504.3(i) NYS Medicaid Program, Information for All Providers, General Policy Versions 2008-1 through 2022-2, Section II NYS Medicaid Program, Dental Policy and Procedure Code Manual Versions 2012-1 through 2025-1, Section I NYS DOH Medicaid Update, January 2008, Vol. 24, No. 1