Connecticut Dental Health Partnership

Adult Benefit Maximum FAQ

Per the notification provided to Dental providers enrolled in the Connecticut Medical Assistance Program (CMAP) via Provider Bulletin 2017-81, an annual dental benefit maximum of $1,000 has been implemented for dental services provided to adult clients ages 21 and older enrolled in HUSKY A, C and D benefit plans for dates of service January 1, 2018 and forward. The dental benefit limit will reset on January 1st of each year. Below are a number of frequently asked questions regarding the adult benefit maximum.

What if I need dental treatment that totals more than my yearly maximum? Can my dentist charge me for the difference over $1,000?

This will depend on the circumstance. If the treatment is medically necessary, your doctor will make a request to perform the treatment. If it is approved, then no, you will not be responsible. However, if the treatment is not medically necessary, then you will be responsible if you choose to have the treatment and sign a consent form allowing the doctor to perform the treatment.

You should know that your dental provider may charge you for the difference between the allowable HUSKY fee and the amount that HUSKY paid for the treatment. You cannot be charged more than this for a covered, partially paid service.

For example, if the allowable fee is $100 and you have $80 left of your $1,000 yearly maximum, HUSKY will pay $80 and the balance of $20 is the amount the provider will ask you to pay. You cannot be asked to pay any more than $20.

Is the $1,000 limit per provider for the year?

No, the annual limit of $1,000 is across all providers you see in the year. The total dollar amount paid for your services across all providers is compared to the annual $1,000 limit.

What services count towards the $1,000 annual limit?

All services, excluding inpatient based and emergency dental services, count towards the annual limit. This includes all types of dentures.

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Are cosmetic procedures covered?

Typically, cosmetic procedures are not covered dental benefits under HUSKY. However, if you lose a front tooth and need a partial denture, the partial denture will be covered. If you lose the partial denture in the same year, a replacement denture will not be covered during the same year.

What happens if I need two root canals and crowns on my teeth?

If the treatment you need is more than the $1,000.00 maximum and is considered medically necessary then the dentist(s) who will provide your treatment will need to submit a prior authorization request. If the prior authorization request is approved, then HUSKY will pay for the dental care you need even if it is above the $1,000.00 limit.

If the treatment is not considered medically necessary or sometimes called elective, then HUSKY will not pay for the treatment. You can appeal the decision or if you decide you want to have the treatment and pay for it yourself, then you must sign consent with your dentist stating that you want to have the treatment and will pay for it.

What if I already had some services prior authorized before January 1, 2018, will I still be covered with the $1,000.00 limit?

Yes, if there are any dental services that have been approved through the prior authorization process, they will count under the limitation and you will be able to receive the services that you have already been approved for.

What are the benefit limitations?

All of the dental services and benefit limitations that applied before January 1, 2018, are still in effect. This means there are limits to the procedures you can receive under HUSKY just as before. For example, if you are a healthy adult, you are entitled to one cleaning, exam and x-ray per year. If you have a complete or partial denture, you are entitled to one complete or partial denture every seven years per dental arch.

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Can my dentist charge me his regular office fees for a dental procedure after I have reached my yearly maximum?

Yes, the provider may charge his usual and customary service fees for a procedure if you agree to receive the service(s) which exceed the yearly maximum. Your dental provider should explain that you will owe a balance for the service(s) and have you sign a consent form which describes the service(s) you are accepting responsibility for, before the service(s) is performed. The provider cannot, after the fact, try to make you pay for services.

If I don't use my entire yearly maximum can it be rolled over into the next year?

No, your $1,000 maximum refreshes each year on January 1st and any unused portion from the previous year will not be available.

What if early in the year I reach my yearly maximum and I need a dental procedure done. Do I have to wait until the next year? Is there any way I can get help paying for the procedure?

If your dental provider feels that the dental procedure needed is medically necessary according to the State regulations, the procedure can be submitted by Prior Authorization along with supporting documentation to and have the procedure approved. If the treatment is not approved, a denial letter will be mailed to you and also to your dental provider. If you receive a denial letter, you have the right to appeal the denial. There will be instructions included with the letter explaining the appeal and administrative hearing process.

If the treatment is denied, you may discuss the treatment with your dental provider and decide if you want to pay for the treatment. Your dentist should provide you with a consent form to sign before the service is performed if you do decide to pay for the treatment.

What if during the year I lose my HUSKY coverage and in the same year I get re-instated, does my maximum pick up where it left off or does it start over?

Your benefits will not start over. They will resume from the balance you had remaining before any lapse in coverage.

For example, you had used $200 of your yearly maximum and then you had a lapse of coverage for two months. Once your coverage is re-instated, you would have $800 left of your maximum for the remainder of the year.

What if I need a complete set of dentures and the cost is over my yearly maximum will the dentures still be covered?

If your provider submits a prior authorization and it is determined that you qualify for dentures according to the HUSKY regulations and you are approved for dentures, they will be covered even if the cost is over your yearly maximum.

Do preventive services like cleanings, x-rays and exams count towards my yearly maximum?

Yes, all dental services, except for inpatient hospital care and emergency services, count toward your yearly maximum.

What is considered to be a medically necessary service?

Any services needed to prevent, identify, diagnose, treat, rehabilitate or improve a person's medical condition, including mental illness, or its effects, in order to maintain the person's achievable health and independent functioning.

What is considered a dental emergency?

A dental condition that shows itself by acute symptoms which includes severe pain, which can place an individual in serious jeopardy, cause impairment to body functions or cause serious dysfunction of any body part or organ if left untreated.

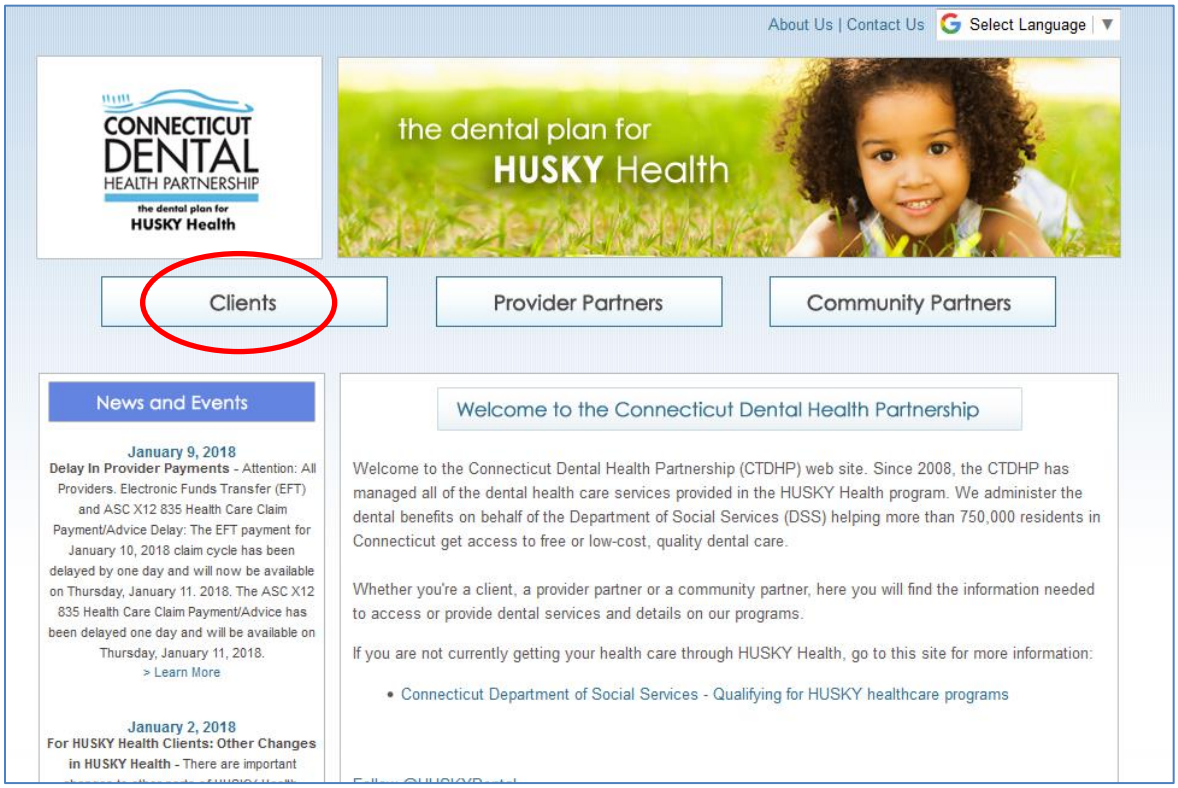
Examples could include:

- Going to the emergency department of a hospital and receive dental treatment

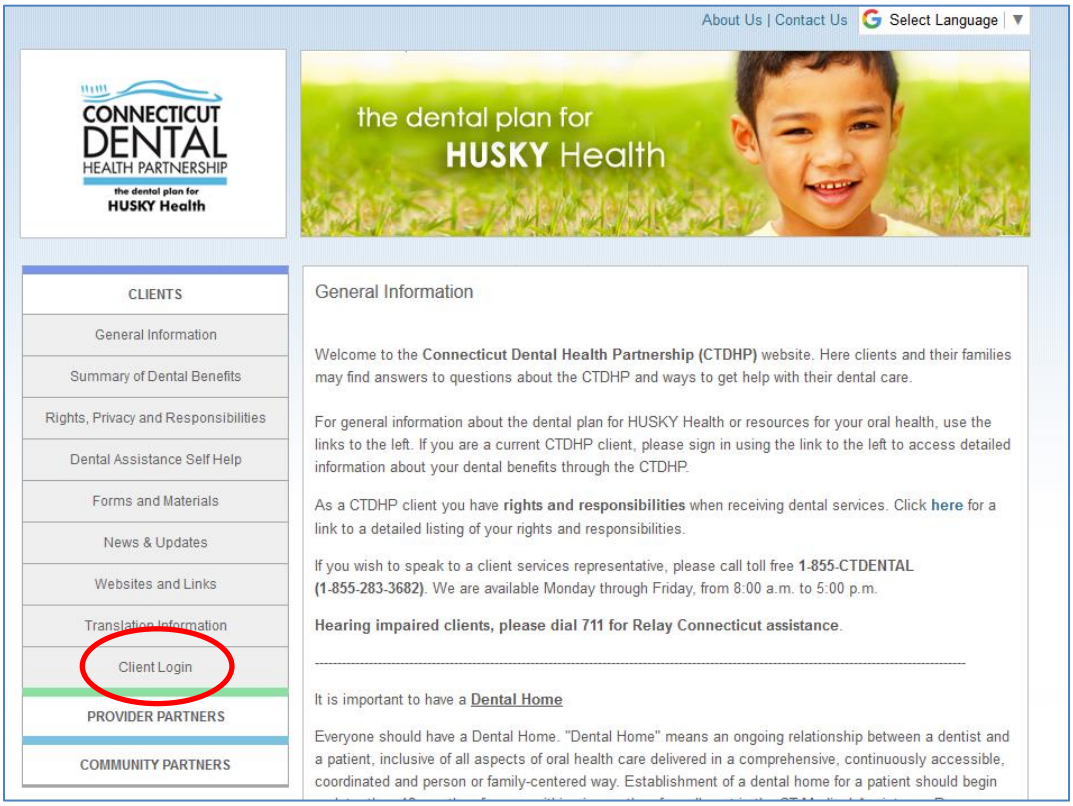
- Going to your dentist with pain and swelling in your mouth and it is determined to be an infection which can affect your overall health
- Trauma to your teeth, facial bones or soft tissue.

How will I know how much benefit I've used/have left?

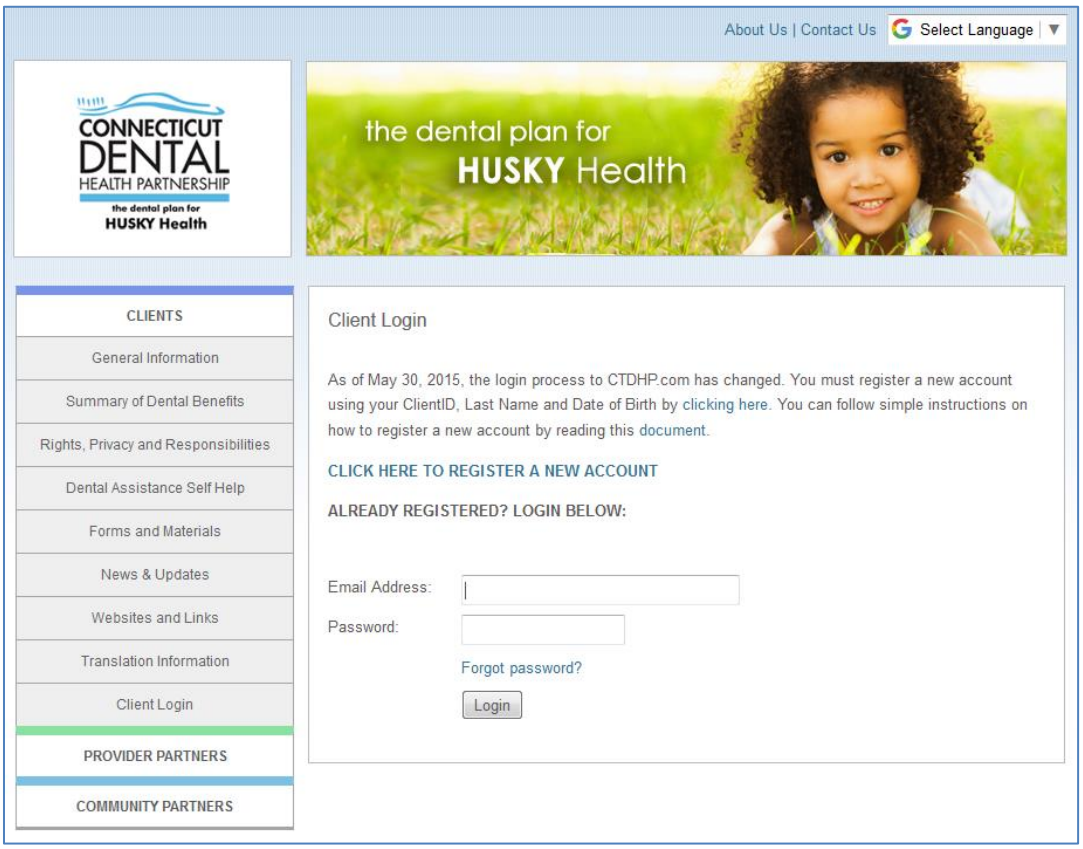
You can ask your dental home provider to check for you or you can check yourself on the Connecticut Dental Health Partnership website, www.ctdhp.com. You will need to login by clicking the 'Clients' button on the home page:



And then selecting 'Client Login' from the menu on the left:



Either create a new account if this is your first visit or provide your account credentials and click 'Login':



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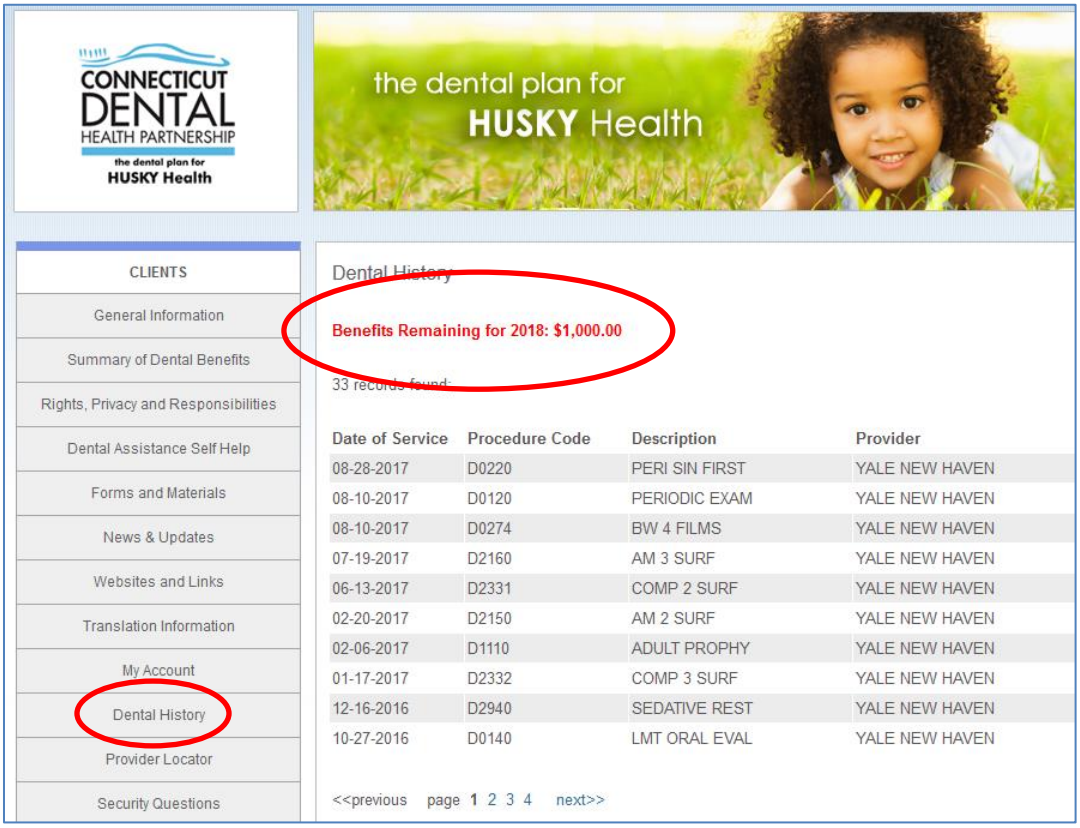
After logging in you can see how much benefit you have remaining by selecting 'Dental History'. You will see something similar to the following:



This benefit information is updated daily.

Will my dentist be able to check how much benefit I've used/have left?

Yes, your dental provider can check on the Connecticut Medical Assistance Program website, www.ctdssmap.com in their provider portal.

Will I be notified when I reach my maximum?

Yes, when you have used 90% of your yearly maximum, you will receive a notice from DSS/DXC Technologies. When you have reached or exceeded 100% of your maximum you will receive another notice from DSS/DXC Technologies.

What will happen if I need dental work from a specialist and my regular dentist to complete my treatment but most or my entire maximum is used before my treatment is finished?

Without an approved prior authorization any remaining treatment that exceeds the yearly maximum would not be covered. Your regular dentist and the specialist should review and discuss your treatment plan before any treatment begins to determine if the services proposed will fall within your $1,000 yearly maximum. If the services exceed the yearly maximum, then a prior authorization to provide the medically necessary services should be submitted by the dentist or specialist.