Dental Coverage Limitations By Program		
Procedure Service	**Common ADA Codes**	**Program Coverage**
Periodic Oral Exam	D0120	For clients under 21 years of age-Limited to one per client per 6 month period. For healthy clients 21 years of age or older-Limited to one per client per calander year. **Note:** When a client has a chronic medical condition (examples include but are not limited to uncontrolled diabetes, organ transplant or is undergoing chemotherapy) which warrants a dental examination more than one time per six (6) month period for a child up to the age of 21 or one time per calander year for over age 21, an additional periodic oral examination may be requested through the established prior authorization/post procedure review process. The prior authorization request must include a description and/or documentation that will justify the medical necessity for the additional examination. **-No HUSKY B Copay** **- Source: Provider Bulletin 2011-61, & chapter 7 of the CT DSS Dental Provider Manual (184E.I.a.3.b)**
Emergency or Limited Oral Exam	D0140	No Limits. **-No HUSKY B Copay** **-Source: Chapter 7 of the CT DSS Dental Provider Manual *(184E.I.a.3.c)***
Initial Oral Exam	D0150	For clients under 21 years of age – One exam per 36 months. For clients 21 years of age or older - Limit to one per client per lifetime. **Note:** When a client changes providers, an additional comprehensive examination service can be requested through the established prior authorization process. **-No HUSKY B Copay** **Source: Provider Bulletin 2011-61 & chapter 7 of the CT DSS Dental Provider Manual *(184.E.I.a.3.a)***
Detailed & Extensive Oral Evaluation	D0160	This examination is used in leu of the comprehensive evaluation for specialists. **-No HUSKY B Copay** **-Source: HP/EDS Fee schedule**
X-Ray-Intraoral, complete series (FMX, Full Mouth Series)	D0210-Full Mouth Series	Intraoral, complete series (full mouth) consisting of at least ten (10) periapical films plus bitewings, limited to once per (36) months. **Note**: Under the HUSKY dental plan, a panoramic or a full mouth series is covered once per 36 months.

		-No HUSKY B Copay **- Source: Chapter 7 of the CT DSS Dental Provider Manual *(184.E.I.a.2.a)***
X-Ray-Periapical	D0220-1st Film D0230-Each Additional Film	For clients 21 years of age or older - Limited to four (4) radiographs per 365 day period. (No frequency restriction for clients under 21 years of age.) Note: The single 1st film is not covered on the same date of service as bitewings, panoramic or lateral jaw films. When a client has a documented need that warrants more than four periapical radiographs in a one year period, an additional service may be requested through the prior authorization process. The prior authorization request must include a description and/or documentation that will support and justify the additional periapical radiograph procedure. -**No HUSKY B Copay** **- Source: Provider Bulletin 2011-61 & chapter 7 of the CT DSS Dental Provider Manual *(184.E.I.a.2.c, 184F.II.a)***
X-Ray-Bitewing	D0270-Single D0272-Two D0274-four	For clients under 21 years of age - Limited to 1 bitewing procedure (D0270, D0272, D0274) per client per 6 month period. For clients 21 years of age or older - Limited to 1 bitewing procedure per client per 12 month period. (Any X-Rays in addition to bitewings & 3 periapicals requires a PA) **-No HUSKY B Copay** **- Source: Provider Bulletin 2011-61, & Chapter 7 of the CT DSS Dental Provider Manual *(184E.I.a.2.b, 184F.II.a)***
X-Ray-Panoramic	D0330-Panoramic Radiograph	Panoramic X-ray is a reimbursable procedure that requires prior authorization for all dental specialties and clinics except for oral and maxillofacial surgeons and orthodontists. Note: Under the HUSKY dental plan, either a panoramic X-ray or a full mouth series is covered under the plan one time per 36 months. When a client has a documented need that warrants a panoramic radiograph, the service can be requested through the prior authorization process. **-No HUSKY B Copay** **- Source: Provider Bulletin 2011-61, Chapter 6 in the CTDHP Provider Manual & Chapter 7 of the CT DSS Dental Provider Manual**
Dental Prophylaxis "Prophy"	D1110 Adult D1120 Pediatric	For clients under 21 years of age-Limited to one per client per 6 month period. For clients 21 years of age or older-Limit to one per client per calander

		year. **<u>Note</u>**: Dental cleaning includes supra & sub gingival scaling & polishing. When a client has a chronic medical condition (examples include but are not limited to uncontrolled diabetes, organ transplant or is undergoing chemotherapy) that warrants a dental prophylaxis more than one time per six (6) month period for a child up to the age of 21 or one time per twelve (12) month period for an adult age 21 and over, an additional prophylaxis can be requested through the prior authorization/post procedure review process. The prior authorization request must include a description and/or documentation that will support and justify the additional procedure. **-No HUSKY B Copay** **- Source: Provider Bulletin 2011-61, fee schedule & chapter 7 of the CT DSS Dental Provider Manual *(184.E.I.b.1)***
Topical Application of Fluoride-Child	D1203-Topical Fluoride	**No longer covered under the HUSKY dental plan as of 01/01/2013.** Replaced by D1208 **- Source: HP/EDS Fee Schedule & 2013 CDT Update**
Topical Application of Fluoride- Adult	D1204-Topical fluoride	**No longer covered under the HUSKY dental plan as of 01/01/2013.** Replaced by D1208 **- Source: HP/EDS Fee Schedule & 2013 CDT Update**
Topical Fluoride Varnish-Therapeutic Application	D1206-Topical Fluoride Varnish- Child or Adult	**No longer covered under the HUSKY dental plan as of 01/01/2013.** Covered only when billed under HUSKY medical benefit **- Source: HP/EDS Fee Schedule & 2013 CDT Update**
Topical Application of Fluoride-Adult & Children	D1208-Topical Fluoride application	For clients less than 21 years of age - Limited to no more than twice (at 6 month intervals) per client per year. For clients 21 years of age or older - Limited to patients who have xerostomia or have undergone head and/or neck radiation therapy and requires PA. **-No HUSKY B Copay** **- Source: HP/EDS Fee Schedule, 2013 CDT update & Chapter 7 of the CT DSS Dental Provider Manual (184E.1.b.2)**
Pit & Fissure Sealants	D1351	Ages 5 through 16, once in a five year period per tooth, limited to tooth numbers shown below. Teeth to be sealed must be free of decay. 2,3,4,5,12,13,14,15,18,19,20,21,28,29,30,31 **-No HUSKY B Copay** **- Source: Provider Bulletin Provider Bulletin 06-103, 09-25 & Chapter 7 of the CT DSS Dental Provider Manual *(184E.1.b.5)***
Space Maintainers	D1510-Fixed Unilateral	D1510 – limit of 4 covered Prior authorization required for some specialties [see fee schedule] D1515 – limit of 2 covered

	D1515-Fixed Bilateral D1525-Removable Bilateral	Prior authorization required for some specialties [see fee schedule] D1525 – limit of 2 covered Prior authorization required for some specialties [see fee schedule] **- Source: HP/EDS Fee Schedule & Chapter 7 of the CT DSS Dental Provider Manual *(184E.1.b.3)*** **HUSKY B Copay-33%**
Recementation of Space Maintainer	D1550	Covered Prior authorization required for some specialties [see fee schedule] **HUSKY B Copay-20%** **- Source: HP/EDS Fee Schedule**
Removal of Fixed Space Maintainer	D1555	Covered Prior authorization required for some specialties [see fee schedule] **HUSKY B Copay-33%** **- Source: HP/EDS Fee Schedule**
Restorations-Fillings-Amalgams (Metal) (1-32, A-T)	D2140 – 1 surface D2150 – 2 surface D2160 – 3 surface D2161 – 4 surface	Once per year to same surface - no primary teeth which are about to come out. **HUSKY B Copay-20%** **- Source: Provider Bulletin 09-25 & Chapter 7 under of the DSS Dental Provider Manual *(184E.I.c.1.(a))***
Restorations-Fillings-Composite Resin (White)	Anterior: D2330 – 1 surface D2331 – 2 surface D2332 – 3 surface D2335 – 4 surface 6-11, 22-27, C-H, M-R Posterior: D2391 – 1 surface D2392 – 2 surface D2393 – 3 surface D2394 – 4 surface 2-5, 12-15, 18-21, 28-31, A, B, I-L, S, T (Teeth #1, 16, 17 & 32 are not covered.)	Once per year to same surface - no primary teeth which are about to come out. For clients 21 years of age or older-Posterior composite resin restorations D2391, D2392, D2393 & D2394 are no longer a covered procedure for first molar teeth (3, 14, 19 & 30) and second molar teeth (2, 15, 18, & 31) or third molar teeth (1, 16, 17, 32). Amalgam-free offices can submit a prior authorization request for procedure D2999 with the notation that the office is amalgam free and with an explanation of tooth number and type of filling. The office will be reimbursed at the amalgam filling rate. **HUSKY B-20% Copay** **- Source: Provider Bulletin 09-25, Provider Bulletin 09-57, Provider Bulletin 11-61 & Chapter 7 of the CT DSS Dental Provider Manual *(184E.I.c.1.(a))***
Crown –Porcelain fused to predominantly base metal (Anterior permanent teeth #4-13 & 20-29	D2751 - Anterior	Crown – Porcelain fused to predominantly base metal – Anterior Teeth Once per five year limitation PA Required Submissions for fillers to smooth out irregularities in the tooth preparation are not benefited because they are considered an integral

only.) (predominantly shows porcelain)		part of the crown procedure and do not constitute a separate billable service. PA submissions must include mounted pre-operative periapical, Pan or FMX (no bitewings) and complete charting of client's dentition including any planned extractions. **HUSKY B Copay 33%** **- Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual *(184E.I.c.2.(c))* & CTDHP Provider Manual Chapter 6**
Crown-Full cast predominantly base metal (Permanent Teeth #1-32) (predominantly shows metal)	D2791	Crown-Full cast predominantly base metal Once per five year limitation PA Required Submissions for fillers to smooth out irregularities in the tooth preparation are not benefited because they are considered an integral part of the crown procedure and do not constitute a separate billable service. PA submissions must include mounted pre-operative periapical, Pan or FMX (no bitewings) and complete charting of client's dentition including any planned extractions. **HUSKY B Copay 33%** **- Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual *(184E.I.c.2.(a))*& CTDHP Provider Manual Chapter 6**
Re-cement Crown	D2910 D2920	**HUSKY B Copay 20%** **- Source: HP/EDS Fee Schedule, Provider Bulletin 09-25**
Crowns-Stainless Steel with Resin Window (Primarily used on children)	D2930-Primary D2931-Permanent D2933-Primary or Permanent	D2930 – Prior Authorization required for some specialties [see fee schedule] D2931 – Prior Authorization required for some specialties [see fee schedule] D2933 – Prior Authorization required for some specialties [see fee schedule] Covered only when breakdown of tooth structure is excessive. D2933 Covered for primary or permanent teeth, anterior or posterior. Crowns are not covered for primary teeth which are about to come out. **HUSKY B Copay 33%** **- Source: Provider Bulletin 09-25, & Chapter 7 of the CT DSS Dental Provider Manual *(184E.I.c.2.(a))***
Restorative Temporary Sedative filling	D2940	Prior authorization required for some specialties [see fee schedule] **HUSKY B Copay 20%** **- Source: Provider Bulletin 09-25 & Chapter 7 of the CT DSS Dental Provider Manual *(184E.I.c.1.(b))***
Core Buildup	D2950	The core buildup replaces part or the entire anatomical crown when

		there is insufficient crown structure remaining to provide mechanical retention for an artificial crown provided said teeth can support the suitable placement of intra-dental pins, without causing damage to the existing pulp and therefore, serves as a base for the artificial crown. This procedure may be used with non-endodontically treated teeth that require an artificial crown when longevity is essential for the tooth in treatment and can demonstrate at least a supportable five year positive prognosis. Posts and cores are to be used solely on endodonticly treated teeth, only when there is insufficient tooth structure remaining resulting in insufficient mechanical retention or coronal strength to support and retain an artificial crown. Submissions for fillers to smooth out irregularities in the tooth preparation are not benefited because they are considered an integral part of the crown procedure and do not constitute a separate billable service. Prior authorization required **HUSKY B Copay 33%** **- Source: Provider Bulletin 09-25**
Pin Retention-per Tooth In Addition To	D2951	**HUSKY B Copay 33%** **- Source: Provider Bulletin 09-25**
Endodontic Therapy – Anterior Teeth (#6-11 or 22-27) PA is required for ages 21 and over	D3310 - Anterior	Once per tooth per Client per lifetime limitation PA is required for 21 & over PA submissions must include mounted pre-operative periapical, Pan or FMX (no bitewings) & complete charting of client's dentition including any planned extractions. **HUSKY B Copay 20%** **- Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual *(184E.I.d.1(a))* & CTDHP Provider Manual Chapter 6**
Endodontic Therapy – Posterior Teeth (# 1-5, 12-16, 17-21, 28-32) PA is required for ages 21 and over	D3320 - Bicuspid D3330 - Molar	Once per tooth per Client per lifetime limitation. PA is required for 21 & over PA submissions must include mounted pre-operative periapical, Pan or FMX (no bitewings) & complete charting of client's dentition including any planned extractions. **HUSKY B Copay 20%** **- Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual *(184E.I.d.1(b))* & CTDHP Provider Manual Chapter 6**
Retreatment Root Canal Therapy	D3346-Anterior D3347-Premolar/Bicuspid D3348-Posterior/Molar	Covered for ages 0-20. Prior authorization required for all providers except Endodontists **HUSKY B Copay 20%** **- Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental**

		Provider Manual *Put in citation*
Apicoectomy/ Periraduclar Surgery	D3410-Anterior D3421-Bicuspid D3425-Molar	Prior authorization is required for under age 21. Endodontists do not require Prior Authorization for these procedures. **HUSKY B Copay 20%** **- Source: Provider Bulletin 09-25, & Chapter 7 of the CT DSS Dental Provider Manual *(184E.I.d.1)***
Apexification	D3351	Not including root canal treatment but includes all visits to complete the service. Restricted up to age 20 – Prior authorization is required all specialties except Endodontists. **HUSKY B Copay 20%** **- Source: Provider Bulletin 09-25, & Chapter 7 of the CT DSS Dental Provider Manual (*184E.I.d.2)***
Gingevectomy or Gingivoplasty	D4210-Four or More Teeth D4211-One to Three Teeth	Prior authorization required for clients age 21 and over. Covered for severe effects caused by medication. **HUSKY B Copay 50%** **- Source: Chapter 7 of the CT DSS Dental Provider Manual *(184F.II.h,i)***
Removable Prosthetic – Full Denture	5110 Full Upper 5120 Full Lower	Covered once per 7 year period. Denture labeling covered for patients in long term care facilities. **Note**: Clients will be required to sign an acceptance form attesting that he or she understands the new replacement policy and that his/her denture prosthesis is acceptable. A supply of the forms will be provided free of charge to providers by the Connecticut Dental Health Partnership. When a client warrants replacement denture prosthesis, more than one time per seven (7) years, the additional denture procedure can be requested through the established prior authorization process. The prior authorization request for replacement dentures must include a description that will justify the medical necessity for additional denture construction procedure(s). If the denture prosthesis was stolen or destroyed by a natural disaster or accidental event, then a copy of the original police, fire marshal or other responding official report must be included with the prior authorization request; however, a report does not guarantee replacement of the dentures. The prior authorization request must also include a description and/or documentation that will justify the medical necessity for the replacement of the denture; dentures will not be replaced for cosmetic reasons. **HUSKY B Copay 50%** **- Source: Provider Bulletin 11-61, CTDHP Provider Manual chapter 6**

Removable Prosthetic – Partial Denture (Requires PA)	5211 Partial Upper Resin Based 5212 Partial Lower Resin Based 5213-Partial Upper Cast metal 5214-Partial Lower Cast metal	Covered once per 7 year period limitation. Denture labeling covered for patients in long term care facilities. **Note**: Clients will be required to sign an acceptance form attesting that he or she understands the new replacement policy and that his/her denture prosthesis is acceptable. A supply of the forms will be provided free of charge to providers by the Connecticut Dental Health Partnership. When a client warrants replacement denture prosthesis, more than one time per seven (7) years, the additional denture procedure can be requested through the established prior authorization process. The prior authorization request for replacement dentures must include a description that will justify the medical necessity for additional denture construction procedure(s). If the denture prosthesis was stolen or destroyed by a natural disaster or accidental event, then a copy of the original police, fire marshal or other responding official report must be included with the prior authorization request;however, a report does not guarantee denture replacement. The prior authorization request must also include a description and/or documentation that will justify the medical necessity for the replacement of the denture; dentures will not be replaced for cosmetic reasons. **HUSKY B-50% Copay** **- Source: Provider Bulletin 11-61, CTDHP Provider Manual chapter 6**
Denture Repairs	D5510-Repair of Broken Complete Denture Base D5520-Replace Missing or Broken Teeth-Complete D5610-Repair Resin Denture Base D5620-Repair Cast Framework D5640-Repair or Replace Broken Clasp D5650-Add Tooth to Existing Partial Denture	**HUSKY B Copay 20%** **- Source: Provider Bulletin 09-25, HP/EDS Fee Schedule**

	D5660-Add Clasp to Existing Partial Denture	
Reline Dentures - Chairside	D5730-Reline Complete Maxillary Denture-Chair side D5731-Reline Complete Mandibular Denture-Chairside D5740-Reline Maxillary Partial Denture-Chair side D5741-Reline Mandibular Partial Denture – Chairside	Once per 2 year period limitation PA Required for some specialties **HUSKY B Copay-20%** **- Source: Chapter 7 of the CT DSS Dental Provider Manual (184E.I.e.4)**
Reline Dentures - Laboratory	D5750- Reline Complete Maxillary Denture D5751- Reline Complete Mandibular Denture D5760- Reline Maxillary Partial Denture D5761- Reline Mandibular Partial Denture	Once per 2 year period limitation Prior Authorization required for some specialties **HUSKY B Copay 20%** **- Source: Provider Bulletin 11-07, & Chapter 7 of the CT DSS Dental Provider Manual (184E.I.e.4)**
Obturator Prosthesis	D5931-Surgical	**HUSKY B Copay 20%** **- Source: Provider Bulletin 09-25, HP/EDS Fee Schedule**
Obturator Prosthesis	D5932-Definitive	**HUSKY B Copay 20%** **-Source: HP/EDS Fee Schedule**
Oral Surgery Limitations: ***Suture Placement:*** *Only Sutures of lacerations of mouth in accident cases only & not cases incidental to and connected with dental surgery.* **Chapter 7 *of the CT DSS Dental Provider Manual (184E.I.f.1)*** ***Reimplantation:*** *Only replant avulsed anterior tooth, not in conjunction with a root canal.* **Chapter 7 *of the CT DSS Dental Provider Manual (184E.I.f.3)***		
Simple Exodontia (Extractions)	D7111 Coronal Remnants, deciduous tooth D7140 – Extraction of erupted tooth or exposed root	Covered for all permanent, primary and supernumerary teeth **20% HUSKY B Copay** **- Source: Provider Bulletin 09-25, & Chapter 7 *of the CT DSS Dental Provider Manual (184E.I.g)***

<table>
<tr><td>Surgical Exodontias (Extractions)</td><td>D7210 - Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth</td><td colspan="2">Covered for all permanent, primary and supernumerary teeth

33% HUSKY B Copay

(Oral Surgeons are not required to submit post procedure review documentation for surgical extractions)

- Source: Provider Bulletin 09-25, & Chapter 7 of the CT DSS Dental Provider Manual (184E.I.g)</td></tr>
<tr><td>Impactions</td><td>D7220-Soft Tissue
D7230-Partially Bony
D7240-Completely Bony
D7241-Completely Bony, with unusual surgical complications</td><td colspan="2">Elective Impactions require special consideration & X-Rays supporting the need for service.
PA Required
HUSKY B Copay 33%

- Source: Provider Bulletin 09-25 & Chapter 7 of the CT DSS Dental Provider Manual (184E.I.g)</td></tr>
<tr><td>Tooth Transplantation (Reposition forming tooth bud to another socket)</td><td>D7272</td><td colspan="2">Restricted to ages 0-20

HUSKY B Copay 20%

- Source: Provider Bulletin 09-25 & Chapter 7 of the CT DSS Dental Provider Manual (184E.I.f.3)</td></tr>
<tr><td>Surgical Access of Unerupted Tooth</td><td>D7280</td><td colspan="2">Covered only for orthodontic reasons – not covered unless orthodontia has been prior authorized.

HUSKY B Copay 20%
- Source: Provider Bulletin 09-25 & Chapter 7 of the CT DSS Dental Provider Manual (184E.II.l)</td></tr>
<tr><td>Osteoplasty</td><td>D7940
D7941
D7944
D7945</td><td colspan="2">Requires PA
HUSKY B Copay 20%

- Source: Chapter 7 of the CT DSS Dental Provider Manual (184E.II.l)</td></tr>
<tr><td>Closure of Salivary Fistula</td><td>D7983</td><td colspan="2">HUSKY B Copay 20%

- Source: Provider Bulletin 09-25</td></tr>
<tr><td>Appliance Removal (Not by dentist who placed appliance)</td><td>D7997</td><td colspan="2">Covered benefit

HUSKY B Copay 20%</td></tr>
<tr><td>Orthodontics

(Required PA)</td><td>D8000-8999

D8660-Pre-Orthodontic Treatment
D8670-Periodic Orthodontic Treatment</td><td>HUSKY A, HUSKY C, HUSKY D
Once per client per lifetime.
Active treatment-max of 30 months per recipient
Work must be performed by a qualified Orthodontist
Limited to recipients under age 21. Therapy must be completed</td><td>HUSKY B
Once per client per lifetime.
Active treatment-max of 30 months per recipient
Work must be performed by qualified Orthodontist
Limited to recipients under age 19
No predetermination required</td></tr>
</table>

	D8692-Replacement of Orthodontic Retainer D8999-Unspecified Orthodontic Treatment	by the age of 21. Prior Authorization required. Orthodontic treatment must be medically necessary and authorized if one of the following conditions are met: • The client obtains 24 or more points on a correctly scored Malocclusion Severity Assessment; or: • The client demonstrates that the requested treatment will significantly ameliorate a mental, emotional or behavioral condition associated with the client's dental condition as certified by a licensed child psychologist/physchiatrist or: • The client presents evidence of a severe deviation affecting the mouth and /or underlying structures. If the client does not satisfy any of the criteria set forth above, a determination is made as to whether the requested services are medically necessary under EPSDT provisions of the Medicaid Act. Under these provisions, orthodontia is approved if medically necessary for the relief of pain or infection, restoration of teeth or maintenance of dental health. 30 visits max / $3410 total ***-Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual (184.E.I.h, 184F.I.c), CTDHP***	Benefit limited to $725.00 per case Client is responsible for balance up to $3410.00

		Provider Manual chapter 6	
Local Anesthesia		It is not payable as a separate service & is included in other procedure codes.	
General Surgical Anesthesia	D9220-Deep Sedation/General Anesthesia-first 30 minutes D9221- Deep Sedation/ General Anesthesia-each additional 15 minutes	Covered for clients under the age of nine (Prior to ninth birthday) or clients that have a demonstrated cognitive impairment/need such as autism, cerebral palsy, hyperactivity disorder or severe/profound developmental delay for behavior management related to the dental procedures to be performed. Covered for clients age nine or over solely for use where multiple oral surgical procedures are performed at the same visit and in cases where five or more extractions are performed or for removal of impacted third molars. ***Not a covered benefit for clients age nine (9) or over for the extraction of a single tooth or general dental services.*** ***Not a covered benefit for clients twenty one or over for the extraction of less than six (6) single teeth-excluding third molars or for general dental treatment*** **HUSKY B Copay is 20%** ***- Source:* Chapter 6 of C*TDHP Provider Manual***	
Analgesia, Anxiolysis, Inhalation of Nitrous Oxide "*Laughing Gas*"	D9230 –Analgesia, Anxiolysis Inhalation NO2	Covered for clients under the age of nine (9)(prior to ninth birthday), or clients of any age who have a **diagnosis such as** autism, cerebral palsy hyperactivity disorder or developmental delay with a demonstrated need for behavior management related to the dental procedures to be performed. ***Not a covered benefit for clients age nine (9) or over for the extraction of a single tooth or general dental services.*** ***Not a covered benefit for clients twenty one or over for general dental services.*** **HUSKY B Copay 20%** ***- Source:* Chapter 6 of C*TDHP Provider Manual***	
Intravenous Conscious Sedation	D9241-Intravenous Conscious Sedation/ Analgesia -first 30 minutes	Covered for clients under the age of nine(prior to ninth birthday) or clients that have a demonstrated cognitive impairment/need such as autism, cerebral palsy, or hyperactivity disorder or severe/profound developmental delay for behavior management related to the dental procedures to be performed.	

	D9242- Intravenous Conscious Sedation/Analgesia - each additional 15 minutes	Also covered for clients age nine or over solely for use where multiple oral surgical procedures are performed at the same visit and in cases where five or more extractions are performed or for removal of impacted third molars. ***Not a covered benefit for clients age nine (9) or over for the extraction of a single tooth or general dental services.*** ***Not a covered benefit for clients twenty one or over for the extraction of less than six (6) single teeth-excluding third molars or for general dental treatment*** **HUSKY B Copay 20%** **- Source: Chapter 6 of C*TDHP Provider Manual***
House/Extended Care Facility/Hospital Call	D9410- House/Extended Care Facility Call D9420-Hospital Call	The House/Extended Care facility call is limited to only private practice dentists and public health hygienists (i.e. not part of a clinic or a group) who provide care to clients external to the office or clinic environment. In the event that a private practice dentist is part of a professional corporation the service can be requested through the established prior authorization process. **-No HUSKY B Copay** ***- Source: Provider Bulletin 11-61***
Patient Management	D9920	Prior Authorization Required Covered only in cases of cognitive disabilities that are limited in their ability to understand directions and require additional time on part of the dentist to deliver services. Provider must document specific diagnosis in patients record, must be moderate to severe or profound mental retardation. Provider must have signature of physician or professional staff member of the Department of Developmental Services attesting the authenticity of the diagnosis. **HUSKY B Copay is 20%** ***- Source: Chapter 7 of the CT DSS Dental Provider Manual (184E.I.k)***
Occlusal "Night" Guards (By Report)	D9940	Covered By Report Prior Authorization required for patients 21 years of age and older **HUSKY B Copay-20%** ***- Source: HP/EDS Fee Schedule & Chapter 7 of the CT DSS Dental Provider Manual (184E.I.b.4)***
Fabrication of Athletic Mouth Guard	D9941	Covered once in a lifetime for clients under age 21 who are enrolled in a **contact** sport. Prior Authorization required. **HUSKY B Copay-20%**

		- Source: HP/EDS Fee Schedule
Periodontia	D4000 – D4999	**Not covered - exceptions for medical necessity in children (EPSDT) considered.** *Gingivectomy only for severe side effects caused by medication.*
Implants	D6000 – D6199	**Not a covered benefit**
Cosmetic Dentistry		**Not a covered benefit**
Vestibuloplasty	D7340, D7350	**Not a covered benefit**
Canceled or Missed Appointments		**Not a covered benefit; cannot charge clients** ***Chapter 7 of the CT DSS Dental Provider Manual (184E.II.m)***