



# **DENTAL PROVIDER MANUAL**

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**Connecticut Dental Health Partnership (The dental plan for HUSKY Health)**

**The Connecticut Department of Social Services**

**BeneCare Dental Plans**





## Welcome to the Connecticut Dental Health Partnership

Dear Doctor:

We are pleased to announce that the State of Connecticut's publicly funded dental care programs, HUSKY A, HUSKY B, HUSKY C (Traditional Medicaid Title XIX Fee For Service) and HUSKY D (Medicaid For Low Income Adults-formerly State Administered General Assistance "SAGA"), now have been combined into one dental plan with a new name: the **Connecticut Dental Health Partnership (CTDHP)**. CTDHP oversees the dental plan for the Department of Social Services (DSS) dental care programs which cover more than 750,000 residents in Connecticut. Participants in the program include the aged, blind and disabled, low income families and adults as well as the state sponsored insurance plan known as SCHIP. The number of beneficiaries is approximately evenly split between children and adults.

DSS is the lead agency for the State of Connecticut which provides a broad range of services to the elderly, people with disabilities, families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. DSS administers over 90 legislatively authorized programs and operates on one-third of the state budget. DSS also administers the Medical Assistance Program which includes the Connecticut Dental Health Partnership.

BeneCare Dental Plans was selected by DSS, in 2008, as the Administrative Service Organization (ASO) to manage the Connecticut Dental Health Partnership for the State of Connecticut. BeneCare is a dental benefit management company that operates dental benefit programs for fully insured and self-insured clients in the Northeast and Mid-Atlantic regions under a wide array of State, County and Municipal government, multi-employer welfare fund and commercial employer sponsored plans.

Please review the material in this manual carefully. The manual is an addendum to the contract you have with the state of Connecticut Medical Assistance Program. Item 10 of the Provider Enrollment Agreement states in part: "To abide by the DSS' Medical Assistance Program Provider Manual(s), as amended from time to time, as well as all bulletins, policy transmittals, notices and amendments that shall be communicated to the Provider, which shall be binding upon receipt unless otherwise noted". Please pay particular attention to the section entitled Connecticut Dental Health Partnership Policy/Standards of Care which contains information on marketing guidelines as well as appointment scheduling guidelines and other important information. The CTDHP will be sharing a variety of programmatic updates and notices with you in the future, so please be on the look-out for communications from the CTDHP and place them in your manual which has been provided in a three ring binder for your convenience.

Thank you for your continued participation in the CTDHP programs and support of Connecticut's neediest residents.

Sincerely,  
Connecticut Dental Health Partnership

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## **Chapter 6 Processes and Procedures**

The CDT Code and Nomenclature referenced in this chapter have been obtained from Current Dental Terminology (including procedure codes; nomenclatures; descriptors and other data contained therein) (“CDT”).

## **CTDHP Prior Authorization Requirements**

As of February 1, 2010, prior authorization (PA) is required for selected services based on client age and provider specialty. The Dental Fee Schedule indicates when a procedure code requires prior authorization or post procedure review. The fee schedule is segmented to show the dental specialties which are enrolled in the program. To see if a procedure code requires PA, locate the procedure code on the fee schedule and read across to the column which contains the dental provider's specialty. Please refer to the legend at the bottom of the current fee schedule for an explanation of the notations used.

A limited number of procedures will be subjected to a post procedure review prior to payment being approved. Dental providers should perform the procedure and submit the appropriate documentation demonstrating the procedure performed to BeneCare. BeneCare's consultants will confirm the procedure was performed and acceptable through post procedure review and will provide authorization for payment.

### **Prior and Post Procedure Authorization Process**

Providers may submit prior authorization requests on paper or electronically. Paper submissions for prior authorization and post procedure reviews must be on an ADA claim form and must be a 2012 version or a later date. The PA request may be handwritten or printed. The requests **do not** have to be on a red ADA claim form. Photocopies of a claim form are also acceptable.

When submitting a PA or PR review request, only the pertinent information should be included. It is not necessary to submit the entire treatment plan. Be sure to clearly document all missing teeth including the teeth that will be extracted which should be denoted by circling the appropriate tooth number on the PA claim form.

The ADA form and all required supporting documentation must be sent to CTDHP/BeneCare at the following address:

CT Medicaid Prior Authorizations  
C/O Benecare  
PO Box 40109  
Philadelphia, PA 19106-0109

Please note, FedEx, UPS and other overnight carriers will not deliver mail requesting a signed receipt to Post Office Boxes.

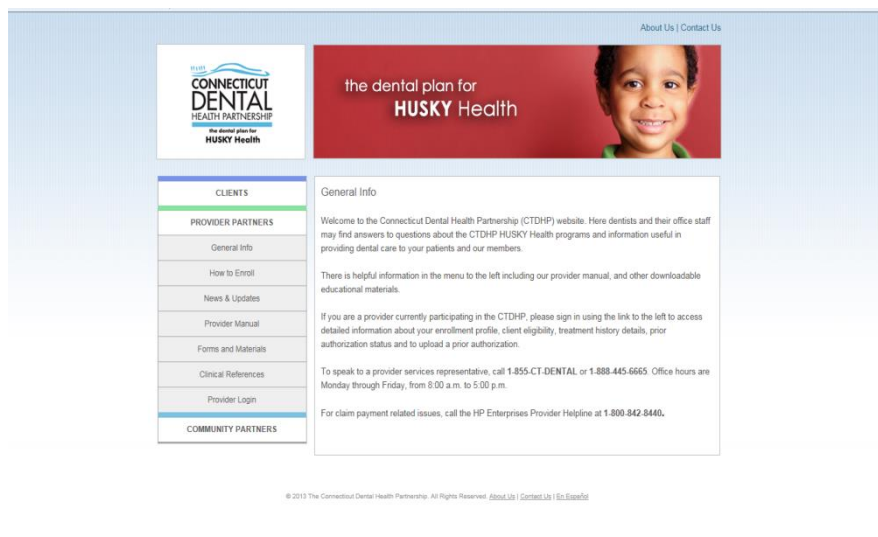


Submissions lacking required documentation will be pended and a request for the missing documentation will be mailed to the submitting dentist. All radiographs will be returned. Digital radiographs supplied in the paper format will be returned if labeled "Return to Provider".

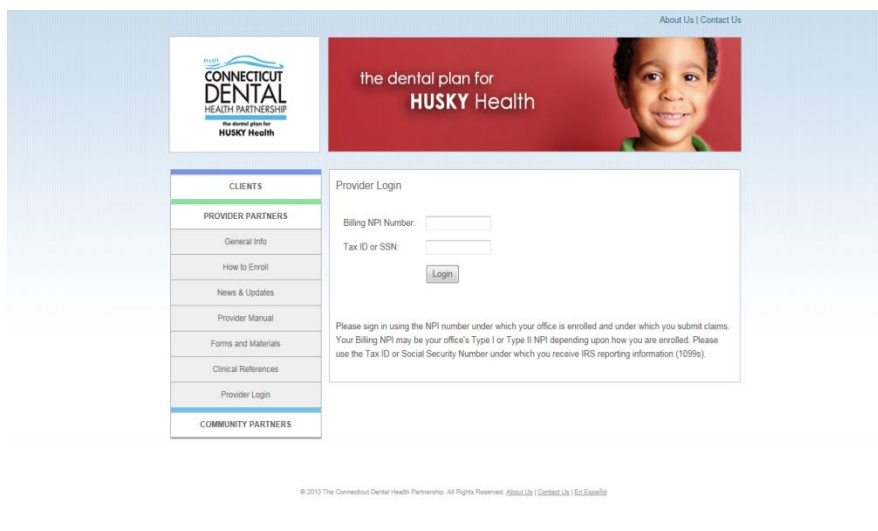
## Electronic Prior Authorization Upload

Providers may electronically request prior authorization for all dental services through the secured portion of the CTDHP website. To upload a Prior Authorization request, follow the steps outlined below:

Access CTDHP at [www.ctdhp.com](http://www.ctdhp.com). Click on **Provider Partners**.

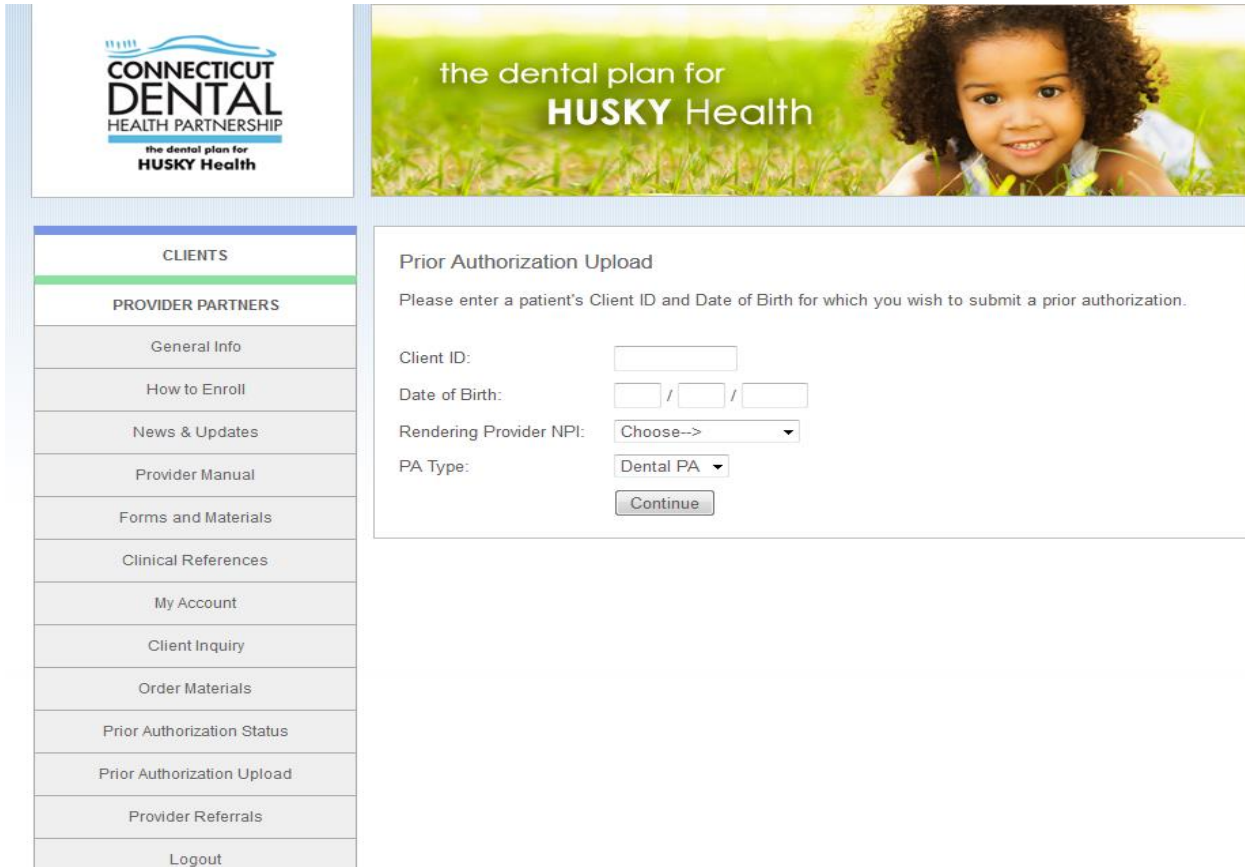


Click on **Provider Login**



Enter your Billing NPI and Tax ID numbers. Click **Login**

Click on **Prior Authorization Upload**



The screenshot shows the website interface for the Connecticut Dental Health Partnership. At the top left is the logo for "CONNECTICUT DENTAL HEALTH PARTNERSHIP" with the tagline "the dental plan for HUSKY Health". To the right is a banner image of a young girl in a field with the text "the dental plan for HUSKY Health". Below the logo is a vertical navigation menu with the following items: CLIENTS, PROVIDER PARTNERS (highlighted), General Info, How to Enroll, News & Updates, Provider Manual, Forms and Materials, Clinical References, My Account, Client Inquiry, Order Materials, Prior Authorization Status, Prior Authorization Upload, Provider Referrals, and Logout. The main content area is titled "Prior Authorization Upload" and contains the following text: "Please enter a patient's Client ID and Date of Birth for which you wish to submit a prior authorization." Below this text are four input fields: "Client ID:" with a text box, "Date of Birth:" with three separate boxes for month, day, and year, "Rendering Provider NPI:" with a dropdown menu showing "Choose-->", and "PA Type:" with a dropdown menu showing "Dental PA". A "Continue" button is located at the bottom of the form.

Enter the Client Medicaid ID and their date of birth. Choose the NPI of the rendering provider from the drop down box. Choose PA type. Click on **Continue**. For Orthodontic PA upload instruction continue to section titled **Ortho PA Upload**.

For non-orthodontic **upload** instructions continue below:

The screenshot shows the 'Prior Authorization Upload' page for HUSKY Health. The page includes a navigation menu on the left with options like 'CLIENTS', 'PROVIDER PARTNERS', and 'General Info'. The main content area is titled 'Prior Authorization Upload' and contains a table with client information. Below the table, there is a section for adding procedure codes, including fields for 'Procedure Code', 'Procedure Date', 'Oral Cavity Area', 'Tooth Number', 'Tooth Surface', and 'Fee'. A red message states: 'Please submit your Prior Authorization request within 20 minutes to avoid being logged out of the system.' and 'No procedure codes have been entered. Please add one below:'.

### Step 1: Add Procedure.

For each procedure code you are requesting prior authorization for, follow the steps outlined below:

- Click on the drop down box next to the Procedure Code field and choose the appropriate code which you are requesting prior authorization for.
- Fill in the procedure date by either manually typing in the date or clicking on the calendar icon and choosing the desired date.
- Fill in Oral Cavity Area, Tooth Number and Tooth Surface if appropriate.
- Fill in your usual and customary fee in the box labeled Fee.
- Click on Add Procedure
- Click on **Edit** if any corrections are required, or you may click on **Delete** to start over.

### Step 2: Add X-rays and/or Supporting Documentation

Click on **Browse** to locate file you wish to upload. Click on the **Upload** icon. If there is more than one file to upload, click on the **Browse** button and **Upload** again to upload the additional file.

**STEP 2: ADD X-RAYS AND/OR SUPPORTING DOCUMENTATION**

Please upload any x-rays or supporting documentation you may have. These documents must be in an image or PDF format. If you have narrative documentation that is in a text or Word document, you can paste that information into the "Step 4: Remarks" box below.

File Name Remove

No files have been uploaded yet. You may upload one below:

Upload File:

File Name:

**Step 3: Indicate Missing Teeth and Teeth to be Extracted**

Locate teeth that are either missing or to be extracted on the chart. Use the drop down arrow to indicate the status of the tooth's presence or absence. An **X** is used to indicate a missing tooth; **O** is used to indicate a tooth schedule to be extracted.

**STEP 3: INDICATE MISSING TEETH (X = MISSING, O = TO BE PULLED)**

Please remember to click the "Update Missing Teeth" button when you are finished with this section.

If your Client has no missing teeth, check here:

If your Client is edentulous, check here:

Otherwise, please indicate individual missing teeth or teeth to be extracted in the grids below:

PERMANENT																	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		

PRIMARY									
A	B	C	D	E	F	G	H	I	J
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
T	S	R	Q	P	O	N	M	L	K

**Step 4: Remarks**

STEP 4: REMARKS

Please remember to click the "Update Remarks" button when you are finished in this section.

4000 characters allowed. 4000 characters left.

[Update Remarks](#)

---

STEP 5: SUBMIT PA REQUEST


[Submit PA Request](#)

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Add any narrative that could be important to the procedure being reviewed. Click Update Remarks.

Once complete, click on **Submit PA Request**.

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CONNECTICUT  
DENTAL  
HEALTH PARTNERSHIP  
the dental plan for  
**HUSKY Health**



the dental plan for  
**HUSKY Health**

CLIENTS

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PROVIDER PARTNERS

- General Info
- How to Enroll
- News & Updates
- Provider Manual
- Forms and Materials

Prior Authorization Upload

Your Prior Authorization Request has been submitted successfully.

If you would like to print a copy of this request, please [click here](#).

To return to the main menu, please [click here](#).

Once the PA request has been successfully submitted, you will receive a confirmation screen. To print a copy of your request and receive your request tracking number, click on the link. Please use this number on all correspondence and communications concerning your PA submission.

## Ortho PA Upload

Enter the Client Medicaid ID and their date of birth. Choose the NPI of the rendering provider from the drop down box. Be sure to choose Ortho PA in the PA type box.. Click on **Continue**.

### Prior Authorization Upload

Please enter a patient's Client ID and Date of Birth for which you wish to submit a prior authorization.

Client ID:

Date of Birth:  /  /

Rendering Provider NPI:

PA Type:

### Step 1: Add Procedure.

For each procedure code you are requesting prior authorization for, follow the steps outlined below:

- Click on the drop down box next to the Procedure Code field and choose the appropriate code which you are requesting prior authorization for.
- Fill in the procedure date by either manually typing in the date or clicking on the calendar icon and choosing the desired date.
- Fill in Oral Cavity Area, Tooth Number and Tooth Surface if appropriate.
- Fill in your usual and customary fee in the box labeled Fee.
- Click on Add Procedure
- Click on **Edit** if any corrections are required, or you may click on **Delete** to start over.

## Ortho Prior Authorization Upload

Please submit your Ortho Prior Authorization request within 20 minutes to avoid being logged out of the system.

Client ID	Name	Date of Birth	Eligibility	Plan	Remove
<input type="text"/>	<input type="text"/>	<input type="text"/>	N	N/A	<input type="button" value="Remove"/>


### ADD PROCEDURE CODES TO BE PRIOR AUTHORIZED (MAX=10)

Procedure Date	Procedure Code	Tooth Number	Tooth Surface	Edit	Remove
----------------	----------------	--------------	---------------	------	--------

No procedure codes have been entered. Please add one below:

#### Add Procedure:

Procedure Code:  (required)

Procedure Date:   mm/dd/yyyy

Oral Cavity Area:

Tooth Number:

Tooth Surface:  B  D  F  I  L  M  O

Fee: \$

## Step 2: Upload Salzman Assessment Form

- Click Browse and select the client specific completed Salzman Score Sheet from your file manager.
- Fill in the score the client received from their Salzman assessment.
- Click the Upload Salzman Assesment Form.

### SALZMAN ASSESSMENT FORM

Directions for uploading the Salzman Assessment form will go here.

File Name	Total Score	Remove
-----------	-------------	--------

Please upload the Salzman Assessment Form information using the form below:

#### Upload Salzman Assessment Form:

File Name:  No file selected.

Score:

### Step 3: Upload Study Model

- Click Browse to locate the study model. Once the saved study model is located click on the file name.
- Click on Upload Study Model.

**STUDY MODELS**  
Directions for uploading Study Models will go here.

**File Name** Remove

Please upload a study model file using the form below:

**Upload Study Model:**

File Name:  No file selected.

### Step 4: Upload X-rays and/or Supporting Documentation

- Click browse to locate saved x-ray and/or documentation.
- Click on Upload Additional File.
- Repeat step 4 if more documents need to be submitted.

**X-RAYS AND/OR SUPPORTING DOCUMENTATION**  
Please upload any x-rays or supporting documentation you may have. These documents must be in an image or PDF format. If you have narrative documentation that is in a text or Word document, you can paste that information into the "Step 4: Remarks" box below.

**File Name** Remove

No additional files have been uploaded. You may upload one below:

**Upload Additional File:**

File Name:  No file selected.

### Step 5: Indicate Missing Teeth and Teeth to be Extracted



Locate teeth that are either missing or to be extracted on the chart. Use the drop down arrow to indicate the status of the tooth's presence or absence. An **X** is used to indicate a missing tooth; **O** is used to indicate a tooth schedule to be extracted. Be sure to click Update Missing Teeth.

**STEP 3: INDICATE MISSING TEETH (X = MISSING, O = TO BE PULLED)**

Please remember to click the "Update Missing Teeth" button when you are finished with this section.

If your Client has no missing teeth, check here:

If your Client is edentulous, check here:

Otherwise, please indicate individual missing teeth or teeth to be extracted in the grids below:

PERMANENT															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

PRIMARY									
A	B	C	D	E	F	G	H	I	J
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
T	S	R	Q	P	O	N	M	L	K

### Step 6: Remarks

**STEP 4: REMARKS**

Please remember to click the "Update Remarks" button when you are finished in this section.

4000 characters allowed. 4000 characters left.

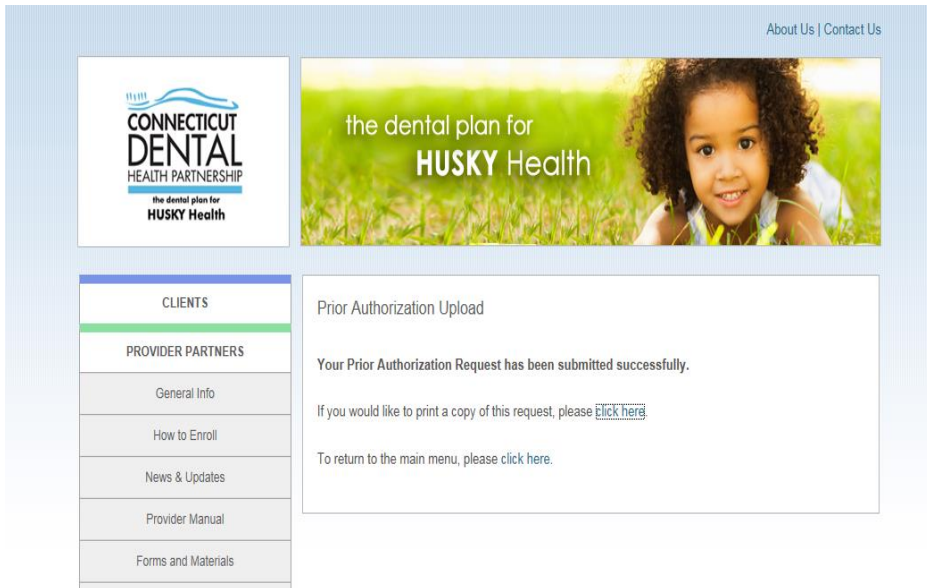
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**STEP 5: SUBMIT PA REQUEST**

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Add any narrative that could be important to the procedure being reviewed. Click Update remarks.

Once complete, click on **Submit PA Request**.



Once the PA request has been successfully submitted, you will receive a confirmation screen. To print a copy of your request and receive your request tracking number, click on the link. Please use this number on all correspondence and communications concerning your PA submission.

## Prior Authorization Processing

***Allow fifteen business days for the review and processing of prior authorization and post procedure review requests. You should schedule patients at least three weeks out from the date of submission.***

Approved prior authorizations/post procedure reviews will be sent to HP Enterprises and will reflect the billing dental provider identifier, client ID and procedure code(s) approved. Prior authorizations will be valid for 365 days from the date of issue. Post procedure reviews will be authorized for the date of actual service and can be billed to HP Enterprises up to 365 from the date of service.

CTDHP/BeneCare will issue a written authorization approval form to the submitting dentist as well. Claims may then be sent to HP Enterprises electronically via the HP Enterprises Web Portal, through your claims submission software or if you prefer paper on a **J434 Red ADA Claim Form**. Please see the Claim Submission section of this manual for more information on billing. A sample PA authorization form is shown below:

```

DEAR DOCTOR:

THIS NOTICE SERVES AS THE STATUS OF A REQUEST FOR THE PRIOR
AUTHORIZATION (PA) OF THE LISTED DENTAL SERVICES FOR THE CONNECTICUT
DENTAL HEALTH PARTNERSHIP CLIENT NOTED BELOW. PA REPRESENTS
A DETERMINATION OF BENEFIT COVERAGE UNDER THE CT DSS MEDICAL
ASSISTANCE PROGRAM POLICY. PA IS NOT A GUARANTEE OF PAYMENT.
PLEASE VERIFY ELIGIBILITY FOR EACH CLIENT APPOINTMENT AS ELIGIBILITY
MAY CHANGE.

PLEASE RETURN THIS LETTER WITH ANY ADD'L DOCUMENTATION REQUESTED. CLAIMS
FOR PAYMENT OF APPROVED AND COMPLETED SERVICES SHOULD BE SUBMITTED TO
HP ON PAPER, VIA WEB PORTAL OR THROUGH YOUR CLAIMS SUBMISSION SOFTWARE.

THANK YOU,

CONNECTICUT DENTAL HEALTH PARTNERSHIP/BENECARE

Client Name:                               Client Nbr
Plan Name: MEDICAID LIA (SAGA)              Claim:
Tooth Sur- Proc Procedure Service Doctors EX
Nbr Face Code Description Date Fee Code
15 02954 PREFAB POS/CO N/A 0
15 03330 ENDO MOLAR N/A 0

0 PA APPROVED

```

Procedure codes for services that are found to be “up-coded” or unbundled as determined by BeneCare will be corrected and the authorization information for those procedure codes will be transmitted to HP reflecting the properly coded procedures. Denied requests will be sent to providers citing the applicable program limitations.

### How to Check Prior Authorization Approvals on the Web

Prior authorization approvals may be checked via the HP Enterprises Web Portal. Your office must have signed up with HP in order to access this secure site. All dental providers can log on to their secure HP Enterprises web account and access the “PA quick link” on the right hand side to access the PA inquiry or by the link on the Menu Bar. Your office can search for prior authorization approvals by the client ID if you have not received notification from the CTDHP with the PA number. Your office may also verify the prior authorization approval by entering the letter "B" followed by the prior authorization number provided by BeneCare. The web address is [www.ctdssmap.com](http://www.ctdssmap.com).

## **Emergency Prior Authorization Requests**

In the event an “emergency” prior authorization is needed, contact CTDHP Provider Service Representatives at 1 – 888 – 445 – 6665 for assistance in determining if the service will meet the state’s medical services policy.

## **Prior Authorization for Federally Qualified Health Centers (FQHCs)**

The reimbursement mechanisms for dental procedures for Federally Qualified Health Centers (FQHCs) are not based on the traditional fee for service (FFS) mechanism for reimbursement to other dental providers. The FQHCs are reimbursed upon an “encounter” rate or for each visit a patient makes to the FQHC. Each FQHC has its own individual rate for reimbursement determined by the Department of Social Services’ client on the Medical Assistant Program.

Due to the type of reimbursement structure for the FQHCs, the Department has a different process for prior authorization determinations. For FQHC facilities, the prior authorizations are granted not only for the procedure but for the number of encounters that may be used to complete a procedure. In the event that there are requests for a singular complete denture or removable partial denture, a set number of visits are allowed to complete the service for the arch. In the event that any combination of upper and lower complete or partial dentures are requested and approved, the total number of encounters approved for the set of dentures is equal to the number of encounters to complete one denture for an arch. If required, additional encounters may be requested and prior authorized.

## **Frequently Asked Questions**

### **1. Q: Which dental services require prior authorization?**

A: Please refer to the dental fee schedule posted at the Connecticut Medical Assistance Program Website: [www.ctdssmap.com](http://www.ctdssmap.com). From the “HOME” web page, go to “Provider”, then select “Provider Fee Schedule Download”, then choose “Dental”. The dental fee schedule now details which services require prior authorization or post procedure authorization by dental specialty.

In summary, services that generally require prior authorization are subject to provider specialty. Services which require prior authorization include:

- Permanent crowns for all provider types
- Stainless steel crowns on primary teeth (consult fee schedule for specialties)
- Root canal therapy
- Replacement fillings for fillings less than one year old provided by any dentist

- Complete Dentures
- Partial dentures
- Orthodontic services provided by any qualified dentist who has been approved to provide orthodontic services by DSS.
- Athletic Mouth Guards
- Any service that exceeds the normal program limitations by any dentist.
- Surgical extractions require post procedure review
- Orthognathic Surgery requires prior authorization.

**Please refer to Fee Schedule for the most up to date listing of procedures which require PA, by specialty. Requirements are subject to change at any time.**

**2. Q: What documentation is required in order to obtain prior authorization?**

A: Please refer to the Connecticut Medical Assistance Program Policy Transmittal 2010-03 which details the documentation requirements by service category. Documentation requirements do not vary by dental specialty.

If the required documentation is not supplied with the original prior authorization or post procedure authorization request, or if additional documentation is needed, CTDHP/BeneCare will request the missing documentation in writing and this will slow down the approval of the request. Sending the required documentation with the original request will ensure the most prompt response. All original documentation such as radiographs, models and photographs will be returned to the submitting office.

**3. Q: Is prior authorization the same as pre-determination?**

A: No. Pre-determination generally refers to a service that a third party benefit provider offers to practitioners so that practitioners may determine what, if any, portion of a proposed treatment plan will be covered by the benefit plan and what portion must be covered by the patient. There is no balance billing or cost sharing provision in the CT Medical Assistance/CTDHP/Medicaid programs, and providers **are prohibited** from charging clients for any portion of delivered dental procedures which are covered on the Medicaid fee schedule.

In this context, prior authorization is required for certain services to ensure that they are rendered in accordance with the Connecticut Medical Assistance Policies governing dental services.

**4. Q: Once a request for prior authorization is approved, how are claims for payment handled?**

A: All payments for Connecticut Medical Assistance Program dental claims will continue to be made by HP in accordance with routine claim adjudication rules, program limitations and client eligibility requirements. After receipt of a prior authorization approval form and the completion of services, or a post procedure authorization approval form, providers must submit their claim for the service for payment to HP via electronic, web portal or paper format.

**5. Q: How long are prior authorizations valid?**

A: Prior authorizations (PA) for prospectively reviewed services will be valid for 365 days from the date of issue. Post procedure authorizations (PR) will be valid only for the specific date(s) of service(s) submitted in the prior authorization request and may be submitted for payment up to 365 after the date of service.

**6. Q: Where do I send my request for prior authorization or post procedure authorization?**

A: Prior Authorization request **should not** be sent to HP for processing. Send fully documented requests for prior authorization or post procedure authorization and any follow up communications for non- orthodontic services to:

CT Medicaid Prior-Authorizations  
C/O Dental Benefit Management, Inc. /BeneCare  
P.O. Box 40109  
Philadelphia, PA 19106-0109

**7. Q: Can I appeal denials of prior authorization or post procedure authorization requests?**

A: Provider appeals are available for services where prior authorization has been requested or requests which have already been completed and which were denied as a result of a request for post procedure authorization. CTDHP/BeneCare has established an internal appeals mechanism for providers. All appeals must be submitted in writing to the above address. If a provider is not satisfied with the final determination upon exhaustion of the CTDHP/BeneCare internal appeals protocols, providers may avail themselves of an independent third party review established by the Department of Social Services.

Clients may also appeal services which have not yet been rendered and which are reduced, suspended or denied as a result of a request for prior authorization. Clients will be notified of

their appeal rights at the same time that prior authorization status notifications are issued to providers. The clients are issued a Notice of Action (NOA) and are given instructions on how to request an Administrative Hearing regarding the denial of service(s).

**8. Q: Can prior authorization be requested for services that are not on the DSS fee schedule?**

A: Any request for prior authorization of a service that is not listed on the DSS fee schedule and is not considered a Medicaid covered service will be returned to the provider unless the services qualify under Section 1905(r) (5) of the Social Security Act. The Act requires that any medically necessary health care service listed at Section 1905(a) be provided to an EPSDT (under 21 years old) recipient when medically necessary.

**9. Q: Can prior authorization be requested for services outside of the program limitations in the DSS Medical Services Policy for dental services?**

A: Yes, under certain circumstances CTDHP/BeneCare will approve additional services beyond the program limitations governing those services. Please submit your specific request with a narrative detailing the need for additional services.

**10. Q: If a prior authorization for additional cleanings and/or exams is approved, will all future exams and cleanings need prior authorization?**

A. Yes, if the next cleaning/exam is performed in the same calendar year for adults or 6 months for children, after the last service, PA will be required.

**11. Q: If a client requests services that are not Medicaid covered services is prior authorization required?**

A: No. Requests for prior authorization made by **clients** at any time will be returned regardless if the service is covered on the Medicaid fee schedule or not.

**Providers** who elect to provide non – Medicaid covered services to Medicaid recipients **must ensure** that they have obtained written informed consent from clients in advance of rendering non-Medicaid covered services. The consent must contain laymen language written at the sixth grade level stating the client understands and accepts responsibility for payment for the rendered non-Medicaid covered services prior to delivery of the service.

**12. Q: If a client prefers a treatment plan that, in the provider’s opinion, will not meet the requirements of the DSS Medical Services Policy, is prior authorization still required?**

A: Providers are strongly encouraged to tailor their recommended treatment plans to agree with the requirements of the DSS Medical Services Policy. If the client insists on a non – conforming treatment, the provider may submit the case for prior authorization. If the service is denied, the documentation of the denial is required to be maintained in the patient’s record along with written informed consent. The client will be responsible for payment of the service if they choose to proceed.

**13. Q: If a provider knows the treatment a patient is requesting does not meet requirements of the DSS Medical Services Policy, is the provider required to submit a pre-authorization for the treatment or can the provider continue with a course of treatment that is covered?**

A: Providers are required to obtain a denied prior authorization request and maintain written informed consent from clients for any circumstance that would result in dental services being delivered to and paid for by the client.

**14. Q: How will alternate benefits be handled?**

A: See 13 above.

**15. Q: What is the expected turnaround time for a decision given a complete prior authorization submission?**

A: On average, approval and/or denial status notices will be issued within fifteen (15) business days from the receipt of a fully documented and complete request for prior authorization or post procedure authorization. Missing documentation, incomplete or illegible ADA claim forms, or other inconsistencies will result in requests being pended until the missing documentation is supplied or required information is obtained.

**16. Q: How do I know if we are using the correct specialty and taxonomy designators in our claims submissions?**

A: If you have any questions about the specialty and taxonomy designators under which you have been enrolled by HP and which designators to use on your claim forms, please contact HP Provider Assistance Center at 1-800-842-8440.

**17. Q: How does the provider taxonomy chart in Chapter 2 apply to my practice?**

A: The chart is there to demonstrate how HP (EDS) has moved from three limited dental specialties to encompass all current dental specialties.



**18. Q: How do I know what the program guidelines are?**

A: Chapter Seven (7) of the Connecticut Medical Assistance Program contains the current dental regulations that CTDHP/BeneCare will use to determine whether or not a service meets qualifying standards under the program. New regulations are expected to be released in the near future. You will be given thirty (30) days notice before any new or updated regulations go into effect.

**19. Q: Will a service that is prior authorized be specific for the patient or provider or both?**

A: Any service that is prior authorized will be specific to both the provider and the client. Additionally, only those procedure codes approved under a given prior authorization or post procedure authorization will be paid for by HP. Submitting different procedure codes, different client IDs, or different provider billing NPI numbers than those listed on the approval status notification will result in denial of payment.

**20. Q: Is there a mechanism to obtain prior authorization over the phone?**

A: Yes. There may be a few instances where a provider may call to see if a client qualifies to receive a service when a patient is in pain. The only services this will be permitted for are endodontic therapy (root canals) and the replacement of a filling that is less than one year old.

The provider's office should call the CTDHP provider relations number (888) 445-6665 between the hours of 8:00 AM and 5:00 PM, Monday through Friday, and have the name and NPI of the billing entity and performing provider, client's name, and client identification number and the proposed procedure to be performed. In addition, the presence or absence of the client's teeth should be included as well as the potential treatment plan for the client.

**21. Q: If the client selects another dentist after prior authorization was obtained, is a new authorization required?**

A: Yes, each provider must obtain prior authorizations specific to their billing NPI number for each patient. The dental office which was granted prior authorization must release the PA to the new office by phoning CTDHP's PA department at (888) 445-6665.

**22. Q: If a client under age 21 is out-of-state attending college, assuming that all other criteria is met, will an exception be granted for a non-participating provider?**

A: No, there is no provision to allow providers who have not yet been enrolled in the CTDHP programs to obtain payments for any services by obtaining prior authorization.

**23. Where dual coverage/coordination of benefits exists, how is the primary carrier determined? If the dentist is non-participating with the Medicaid Programs, assuming all other criteria is met, will an exception be granted?**

A: No accommodations for non-participating providers seeking coordination of benefits with Medicaid will be made. Unless the provider submits the prior authorization or post procedure authorization as a coordination of benefits claim with alternate carrier information, and the provider is participating in the CTDHP programs, all requests will be handled as primary carrier claims.

**24. Q: Does a continuity of care provision exist for approved multi-visit procedures that began while the client was eligible for benefits or had not yet reached the maximum age limit? If not, what are the provider's requirements for requesting payment from the client?**

A: Services such as root canal therapy, crowns, and dentures which require multiple visits should be scheduled for completion as soon as is practicable to ensure client's continued eligibility. Prior authorizations, post procedure authorizations and claim payments cannot be made for ineligible clients.

**25. Q: Does a continuity of care provision exist for the completion of an approved treatment plan begun before the provider's participation terminated? If not, what are the provider's requirements for requesting payment from the client?**

A: Prior authorizations, post procedure authorizations and claims payments can not be made for providers whose enrollment with CTDHP programs have expired and who have not re-enrolled.

**25. Q: Does a continuity of care provision exist for the completion of an approved treatment plan begun before the client eligibility is terminated? If not, what are the provider's requirements for requesting payment from the client?**

A: No prior authorizations, post procedure authorizations or claims payments can be made for clients whose eligibility with the CTDHP program has terminated or expired. A client's eligibility **MUST** be verified at each appointment. Clients who are not eligible for Medicaid during a scheduled visit should be made aware that they will be responsible for payment of services provided during that visit. The provider is strongly encouraged to discuss continued treatment with each client who becomes ineligible during a course of treatment or whose treatment plan is not completed.

**26. Q: What is the process for obtaining approval or payment of services not otherwise included on the list of Medicaid covered services for those clients identified as having special needs by a medical diagnosis code?**

A: Under certain circumstances CTDHP/BeneCare will approve additional services beyond the program limitations governing those services. Please submit your specific request with a narrative detailing the need for additional services.

**27. Q: What is the correct way to discuss and bill for a procedure where the client requests an upgrade? For example, a client requests a composite resin restoration when an amalgam is the covered benefit?**

A: In instances where a client requests a more costly procedure when a less costly benefit is paid by the Medicaid program, **the client becomes responsible for the entire charge of the upgraded service.** The client can never be balance billed for a service covered under the CTMAP program guidelines.

**28. Q: What if Medicaid covers a cast crown for a posterior tooth but the client wants a porcelain fused to metal crown?**

A: In this one exception, at the provider's discretion, a no charge upgrade can be made for the client. The client may be provided with a porcelain fused to metal crown if the provider agrees to charge Medicaid for the cast metal crown. If the client requests a high noble metal or other premium crown, the client may pay for the entire cost of the premium crown. The client can never be balance billed for a service covered or billed to the CTMAP program. In summary, the provider cannot bill Medicaid, receive payment and collect the balance due for the premium crown from the client or a third party representing the client.

## **Coverage Decision Guidelines**

The following tool has been developed to assist dental providers in determining if a procedure would likely be a covered service, and should therefore be submitted for approval. Guidelines have been developed for endodontic therapy, single crown restorations, dentures and denture replacements.

### **Endodontic Therapy Guidelines - Anterior permanent teeth (numbers 6 – 11 or 22 – 27):**

1. Is the client currently eligible for dental services under Medicaid?

- a. Yes, proceed to #2
  - b. No, services cannot be reviewed or covered
2. Is the patient under 21 years old?
    - a. Yes, post review required with submission of final film for endodontic therapy
    - b. No, continue to #3
  3. Does the tooth in question have a favorable prognosis free of periodontal involvement; free from root fracture(s); sufficient crown structure remains to restore tooth to function?
    - a. Yes, proceed to #4
    - b. No, endodontic therapy would not meet coverage guidelines. Recommend alternative treatment modality
  4. Is the tooth to be treated the only tooth requiring endodontic therapy?
    - a. Yes, proceed to #5
    - b. No, for each tooth in question, return to #3 above for all teeth being considered for endodontic therapy
  5. Are other missing teeth in the same arch as the tooth in question to be restored with a partial denture?
    - a. Yes, endodontic therapy would not meet coverage guidelines. Recommend alternative treatment modality
    - b. No, proceed to #6
  6. Submit prior authorization request including mounted pre-operative periapical x-ray for each tooth that requires endodontic therapy, PAN or FMX (no bitewing x-rays will be accepted), and complete charting of the client's dentition (including any planned extractions).

**Endodontic Therapy Guidelines - Posterior permanent teeth (numbers 1-5, 12-16, 17-21, 28-32)**

- 1) Is the client currently eligible for dental services under Medicaid?
  - i) Yes, proceed to #2
  - ii) No, services cannot be reviewed or covered
- 2) Is the patient under 21 years old?
  - i) Yes, post review required with submission of final film for endodontic therapy

- ii) No, proceed to #3
- 3) Does the tooth in question have a favorable prognosis free of periodontal involvement; free from root fracture(s); sufficient crown structure remains to restore tooth to function?
  - i) Yes, proceed to #4
  - ii) No, endodontic therapy would not meet coverage guidelines. Recommend alternative treatment modality
- 4) Does the client have intact dentition (other than third molars or bicuspid extracted for orthodontic therapy) in the quadrant of the tooth to be treated?
  - i) Yes, proceed to #9
  - ii) No, proceed to #6
- 5) Does the client have eight (8) or more natural or restored posterior teeth in occlusion?
  - i) Yes, proceed to #6
  - ii) No, is the tooth in question the last potential abutment tooth for a partial denture?"
    - (a) Yes, proceed to #6
    - (b) No, proceed to #7
- 6) Does the tooth in question have a natural or restored tooth in occlusion?
  - i) Yes, would the extraction of the tooth in question result in fewer than 8 posterior teeth in occlusion?
    - (a) Yes, client appears to qualify for bilateral partial denture, proceed to #9
    - (b) No, proceed to #8
  - ii) No, proceed to #7
- 7) Does the client currently have bilaterally missing teeth in the same arch as the tooth in question?
  - i) Yes, is the tooth in question the last potential abutment tooth for a partial denture?
    - (a) Yes, proceed to #9
    - (b) No, endodontic therapy would not meet coverage guidelines. Recommend alternative treatment modality in order to completely restore the arch

- ii) No, Proceed to #8
- 8) Would the extraction of the tooth in question create bilaterally missing teeth in the arch of the tooth in question?
- i) Yes, proceed to #9
  - ii) No, endodontic therapy would not meet coverage guidelines. Recommend alternative treatment modality
- 9) Submit prior authorization request including mounted pre-operative periapical x-ray for each tooth that requires endodontic therapy, PAN or FMX (no bitewing X-rays will be accepted) and complete charting of the client's dentition (including any planned extractions).

## Single Crown Guidelines - Anterior permanent teeth (numbers 6-11, 22-27)

If the below criteria is met, D2751, Porcelain Base Metal Crowns are covered benefits for tooth numbers 4-13 and 20-29 only. D2791, Full Cast Base Metal crowns are covered benefits for tooth numbers 1-32.

Posts and cores are to be used solely on endodontically 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.

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, including any 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.

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.

1. Is the client currently eligible for dental services under Medicaid?
  - a. Yes, proceed to #2
  - b. No, services cannot be reviewed or covered
  
2. Does the tooth in question have a favorable prognosis free of periodontal involvement; free from root fracture(s); sufficient crown structure remains to restore tooth to function?
  - a. Yes, proceed to #3
  - b. No, a single crown restoration would not meet coverage guidelines. Recommend alternative treatment modality
  
3. Has the tooth in question incurred the loss of four (4) or more tooth surfaces including the loss of one (1) incisal angle?
  - a. Yes, proceed to #4
  - b. No, a single crown restoration would not meet coverage guidelines. Recommend alternative treatment modality
  
4. Is the tooth to be treated the only tooth requiring restorative procedures?
  - a. Yes, proceed to #5
  - b. No, for each tooth in question return to #3 above for all teeth being considered for restorative procedures

5. Are other missing teeth in the same arch as the tooth in question to be restored with a partial denture?
  - a. Yes, a single crown restoration would not meet coverage guidelines. Recommend alternative treatment modality
  - b. No, proceed to #6
  
6. Submit prior authorization request including mounted pre-operative periapical x-ray for each tooth that requires an artificial crown, PAN or FMX (no bitewing x-rays will be accepted), and complete charting of the client's dentition (including any planned extractions).



## **Single Crown Guidelines - Posterior permanent teeth (numbers 1-5, 12-16, 17-21, 28-32)**

If the below criteria is met, D2751, Porcelain Base Metal Crowns are covered benefits for tooth numbers 4-13 and 20-29 only. D2791, Full Cast Base Metal crowns are covered benefits for tooth numbers 1-32.

Posts and cores are to be used solely on endodontically 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.

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 including pins without 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.

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.

1. Is the client currently eligible for dental services under Medicaid?
  - a. Yes, proceed to #2
  - b. No, services cannot be reviewed or covered
  
2. Does the tooth in question have a favorable prognosis free of periodontal involvement and free from root fracture(s) and sufficient crown structure remains to restore tooth to function?
  - a. Yes, proceed to #3
  - b. No, a single crown restoration would not meet coverage guidelines. Recommend alternative treatment modality
  
3. Has the tooth in question incurred the loss of:
  - a. Premolar teeth – the loss of three (3) or more tooth surfaces including one (1) cusp?
    - i. Yes, proceed to #4
    - ii. No, a single crown restoration would not meet coverage guidelines. Recommend alternative treatment modality
  - b. Molar teeth – the loss of four (4) or more tooth surfaces including two (2) cusps?
    - i. Yes proceed to #4

- ii. No, a single crown restoration would not meet coverage guidelines. Recommend alternative treatment modality
- 4. Does the client have intact dentition (other than third molars or bicuspid extracted for orthodontic therapy) in the quadrant of the tooth to be treated?
  - a. Yes, proceed to #9
  - b. No, proceed to #5
- 5. Does the client have eight (8) or more natural or restored posterior teeth in occlusion?
  - a. Yes, proceed to #6
  - b. No, is the tooth in question the last potential abutment tooth for a partial denture?
    - i. Yes, proceed to #6
    - ii. No, a single crown restoration would not meet coverage guidelines. Recommend alternative treatment modality
- 6. Does the tooth in question have a natural or restored tooth in occlusion?
  - a. Yes, would the extraction of the tooth in question result in fewer than 8 posterior teeth in occlusion?
    - i. Yes, is the tooth in question the last potential abutment tooth for a partial denture?
      - 1. Yes, client appears to qualify for a single crown. Proceed to #9
      - 2. No, proceed to #8
    - ii. No proceed to #7
  - b. No, would the extraction of the tooth in question result in fewer than 8 posterior teeth in occlusion?
    - i. Yes, proceed to #7
    - ii. No, a single crown restoration would not meet coverage guidelines. Recommend alternative treatment modality
- 7. Does the client currently have bilaterally missing teeth in the same arch as the tooth in question?
  - a. Yes, is the tooth in question the last potential abutment tooth for a partial denture?
    - i. Yes, proceed to #9
    - ii. No, a single crown restoration would not meet coverage guidelines. Recommend alternative treatment modality
  - b. No, proceed to #8

8. Would extraction of the tooth in question create bilaterally missing teeth in the arch of the tooth in question?
  - a. Yes, proceed to #9
  - b. No, a single crown restoration would not meet coverage guidelines. Recommend alternative treatment modality
  
9. Submit prior authorization request including mounted pre-operative periapical x-ray of the tooth to be treated, PAN or FMX (no bitewing x-rays will be accepted), and complete charting of the client's dentition (including any planned extractions).

### **Bilateral Partial Denture, Initial Placement Guidelines (D5211, D5212, D5213, D5214)**

Partial dentures are subject to a once every seven (7) years per client replacement frequency limitation.

1. Is the client currently eligible for dental services under Medicaid?
  - a. Yes, proceed to #2
  - b. No, services cannot be reviewed or covered
  
2. Does the client have any missing anterior teeth in the arch being considered for the partial denture?
  - a. Yes, proceed to #6
  - b. No, proceed to #3
  
3. Does the client have eight (8) or more natural or restored posterior teeth in occlusion?
  - a. Yes, partial dentures are not a covered benefit for clients retaining eight (8) or more natural or restored posterior teeth
  - b. No, proceed to #4
  
4. Is there a treatment plan that includes extraction of any teeth in the arch being considered for the partial denture?
  - a. Yes, will planned extractions result in the client having any missing anterior teeth or fewer than eight (8) natural or restored posterior teeth in occlusion?
    - i. Yes, proceed to #5
    - ii. No, partial dentures are not a covered benefit for clients retaining eight (8) or more natural or restored posterior teeth
  - b. No, proceed to #5

5. Do the abutment teeth in the arch being considered for the partial denture in question each have a favorable prognosis free of periodontal involvement and free from root fracture(s) and sufficient crown structure remains to support the prosthesis?
  - a. Yes, proceed to #6
  - b. No, address existing condition(s) of potential abutment teeth prior to requesting authorization for a partial denture. Partial dentures are not a covered benefit where the supporting tooth structures have unfavorable prognosis
  
6. Is the denture expected to be used for mastication on a daily basis?
  - a. Yes, proceed to #7
  - b. No, the denture recipient is expected to be alert and is expected to use the denture for mastication on a daily basis. Prostheses for aesthetic purposes are not covered benefits
  
7. Submit prior authorization request including mounted preoperative periapical X-rays of the remaining dentition, PAN or FMX (No bitewing x-rays will be accepted), and complete charting of the client's dentition (including any planned extractions)

### **Denture Benefit**

Full or partial dentures are a covered service which requires prior authorization. CTDHP has developed a new brochure, "Caring for Your Dentures", which covers basic information for your patients regarding the attention they will need to give their new dentures. It is important that each client receive this brochure and understand his or her rights and responsibilities involved with the receipt of the appliance(s).

Due to the high number of claims for replacement of ill fitting, lost, stolen or broken dentures, a new form "Client Acknowledgement of Receipt of Denture(s) and a description of the Policies for Replacements" has been created. When you deliver denture(s) to a CTDHP client, please have them read and initial/sign the form. Keep the original signed copy of the form in the client's chart.

Supplies of the brochure and acknowledgement forms were sent to each enrolled dental office which has provided dentures. Additional supplies of these documents can be requested through the CTDHP website ([www.ctdhp.com](http://www.ctdhp.com)) or by telephoning 860-507-2304.

## Denture Replacement Requirements

There is a seven (7) year frequency limitation on full and partial dentures which have been previously benefitted for clients covered under the State of Connecticut Medicaid dental programs for HUSKY A, HUSKY B, HUSKY C (Medicaid Title XIX) and HUSKY D (Medicaid LIA). All denture replacements within the seven year frequency limitation require prior authorization. **Medicaid will not be able to cover new denture appliance(s) earlier if the denture(s) are lost, damaged, or destroyed.** Dentures will only be replaced if the patient uses his or her denture(s) on a daily basis, or if they are needed due to reasons of medical necessity.

In order for a denture replacement to be considered for prior approval within the seven year frequency limitation, the following documentation must be submitted with the prior authorization request:

- Attestation from the patient's independent primary care or attending physician, on their letterhead, detailing the medical reason(s) and the medical necessity for the replacement appliance. Such attestation should detail any functional difficulties that the missing appliance has caused and affirm that a replacement appliance is necessary to ameliorate that specific condition. It is not sufficient to list a medical condition with the statement "needs dentures to eat".
- For partial dentures, a full mouth series of x-rays or panoramic x-ray and complete charting of missing teeth on a standard ADA claim form should be submitted. Also, please note any planned restoration needs and/or extractions of remaining teeth.
- For patients that attest their denture was stolen or lost during a personal altercation, due to fire or other calamity, a copy of the police or fire marshal report detailing the situation and denture loss is necessary.
- If the patient resides in a skilled nursing facility, please supply the following additional information:
  - Copies of the facility dietitian's logbook records detailing any change in diet or meal consumption which has occurred due to the absence of the appliance being considered for replacement.
  - Affirmation from the facility nursing director or other caretaker that the patient uses the denture(s) to eat and that the patient desires a replacement appliance.
  - Dentures will only be replaced on a one time basis in a seven (7) year period. Loss of the replacement denture prosthesis more than one time in the seven (7) year limitation will not be benefitted regardless of the reason.

**Replacement denture requests that do not include the above documentation will be denied.**

## **Radiograph Guidelines**

The CTDHP guidelines for billing and compensation for radiographs are outlined below:

- A complete intraoral series is billed when the fees for any combination of periapical/bitewing intraoral radiographs in a single treatment series meets or exceeds the Medicaid fee for a complete intraoral series.
- A panoramic film with supplemental bitewing films may be substituted, however the total reimbursable amount will be limited to the Fee Schedule rate for a complete intraoral series.
- The potential pathological condition for taking any periapical radiograph on a young child must be clearly documented in the client's chart. A panoramic film with bitewing and additional periapical radiographs will be reimbursed at the Fee Schedule rate for an intraoral complete series if medically necessary. Such documentation should accompany the claim to expedite processing.
- Beginning May 1, 2015, bitewing radiographs will be limited to one time in a calendar year and will be disallowed within twelve (12) months of a full mouth series unless warranted by special circumstances that meet medical necessity definitions. A complete intraoral series and panoramic film are each limited to once every 36 months.

## **Prior Authorization Appeals**

Effective February 1, 2010, certain dental services are subject to prior authorization or post procedure reviews. CTDHP's dental consultants will review claims and accompanying documentation in order to determine if requests for prior authorization or post procedure authorization agree with the Connecticut Department of Social Services Medical services Policy regulations pertaining to dental services and to community standards of care and professional best practices.

### **How to Appeal a Denied Request**

When a prior authorization request is denied or a post procedure review is down-coded, your office has the availability of requesting a reconsideration of the PA or PR procedure. There is a process in place that must be followed. Most frequently, a PA or PR was denied because of the lack of information. Dentists wishing to appeal denial determinations may use the following process. Please note that the clients and the dentists have independent and different appeal rights. Clients only have the option to use the appeal protocols that are outlined in the Notices of Action (NOA) documentation that is mailed to them when a service is denied.

### **Administrative Denial Appeals**

Administrative denials occur when the client is found to be ineligible for services due to administrative reasons such as the client is no longer enrolled in Medicaid or the client has met the spend – down amount needed to become enrolled in the Medical Assistance Program. Other reasons for administrative denials may even include reasons such as the failure to follow administrative procedures. An administrative appeal may be made in writing or via the telephone. Updated information provided may result in the need for a prior authorization or post procedure review evaluation by the dental consultants. This should be brought to the attention of the representative handling the inquiry or documented in writing. The representative handling the inquiry will then determine if the request can be reviewed and what if any further documentation is required to complete a review of the request.

Turnaround time: Telephone inquiries that do not result in review of the request will be resolved immediately. If the administrative review has a clinical component when the receipt of all information deemed necessary and sufficient to render an evaluation or re-evaluation, the case will be sent to the dental consultants for review. Notification of the approval or the denial will be mailed within ten business days. The notification will state if the original determination was upheld or the decision was made to overturn the denial.

## Clinical Denial Appeals

**1. Level One Appeal:** Level one appeals include requests for reconsideration of a prior authorization or post procedure review request that was denied as a result of a dental consultant's determination that a service is not medically necessary. You can have a request for a reconsideration of the denial. Requests may be submitted in writing or by telephone no later than seven business days from the date of issuance of the denial notification. Any additional documentation that you want to include such as chart notes, a written description, photographs and/or radiographs should be included with the request. Reconsiderations will be conducted by a dental consultant other than the consultant who made the initial determination.

**Turnaround time:** Reconsideration determination notices will be mailed to your office no later than five business days, after the receipt of all information deemed necessary and sufficient to render a new determination on the appeal.

**2. Level Two Appeal:** A level two appeal is your request to have another evaluation of the first clinical denial determination. Level two appeals must be submitted in writing no later than seven business days from the date of issuance of the denial notification. Level two appeals will be considered by the DSS Dental Director, CTDHP/BeneCare Dental Director and dental professionals external to the Department of Social Services or BeneCare.

**Turnaround time:** Reconsideration determination notices will be mailed no later than ten (10) business days after the receipt of all information deemed necessary and sufficient to render a determination on the appeal.

**3. Level Three Appeal:** Providers who wish to avail themselves of further appeals after using the appeal mechanisms described above may submit external appeals through the mechanism described under CT MAP Regulations 184G.I. External appeals must be submitted in writing no later than seven business days after the issuance of a level two denial notification. External appeals will be referred through the DSS Dental Director to the Connecticut State Dental Association in accordance with the Department of Social Services Medical Services Policy 184G.I.

**Turnaround time:** Notifications of the decisions from external review will be issued within ten business days of the determination being rendered by the reviewing body.

### Written appeals should be mailed to:

**BeneCare Dental Plans  
CT PA/PR Appeals  
P.O. Box 40109  
Philadelphia, PA 19106-0109**

Any questions regarding this process should be directed to the CTDHP/BeneCare provider relations staff at: (888) 445-6665.



## Early Periodic Screening Diagnosis and Treatment

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a component of the Medicaid program that is designed specifically for children under the age of 21.

Since its inception in 1967, the purpose of the EPSDT program is to ascertain, as early as possible, the conditions that can affect children and to provide "continuing follow up and treatment so that detrimental conditions do not go untreated. The EPSDT protocol follows the standards of pediatric care in order to meet the special physical, emotional and developmental needs of children enrolled in the Connecticut Dental Health Partnership (CTDHP). EPSDT offers a very important way to ensure that young children receive appropriate health, mental health and developmental services.

The elements of EPSDT, also serve as an acronym for the fundamentals of interceptive care which it entails:

<b>Acronym</b>	<b>Element</b>
Early Identification	Identifying problems early, starting at birth;
Periodic Checking	Evaluating children's health at pre-determined time and age appropriate intervals;
Screening	Performing physical, mental, developmental, dental, and hearing, vision, and other screening tests to detect potential problems;
Diagnosis	Performing diagnostic tests to follow up when a risk is identified; and
Treatment	Treatment of the problems found.

The treatment component of EPSDT is broadly defined. Federal law states that treatment must include any "necessary health care, diagnostic services, treatment, and other measures" that fall within the federal definition of medical assistance (as described in Section 1905(a) of the Social Security Act that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services." EPSDT is designed to help ensure access to needed services, including assistance in scheduling appointments and transportation coordination assistance to keep

appointments. As described in federal program rules: The EPSDT program consists of two, mutually supportive, operational components:

**Assurance** of the availability and accessibility of required health care resources; and

**Assisting** Medicaid recipients and their parents or guardians to effectively use them.

The CTDHP function is to provide clients with all covered services that are "medically necessary."

Medically necessary means medical, dental and behavior related services needed to:

- Keep the client as healthy as possible;
- Improve the client's health;
- Identify or treat an illness or condition, and
- Help the clients function on their own.

Medically necessary services must:

- Meet generally accepted standards of medical care;
- Be the right type, level, amount or length for the client;
- Be provided in the right health care setting;
- Not be provided as a convenience for the client or a provider;
- Cost no more than a different service that will produce the same results, and
- Be based on the client's specific medical condition.

To request an EPSDT related service, that is not listed on the DSS fee schedule, for a client under the age of twenty – one:

1. Fill out the standard PA claim form; be sure to check off the correct box contained in question 1 which states "EPSDT/Title XIX
2. Fill out the PA claim form including all of the necessary information, including your usual and customary charge for the actual ADA CDT procedure codes requested
3. Include all documentation which includes but is not limited to:
  - ◆ Radiographs;
  - ◆ Photographs;
  - ◆ Diagnostic test results;
  - ◆ Physician, behavioral or other health care professionals' referral documentation detailing the underlying condition requiring EPSDT related dental services;
  - ◆ Clinical description of the condition and potential detrimental effect if left untreated; and
  - ◆ Proposed treatment (including length of treatment if applicable).

4. Mail the claim form and documentation for non-orthodontic EPSDT requests to:

**CT Medicaid Prior Authorizations  
CO/Dental Benefit Management/BeneCare  
PO Box 40109  
Philadelphia, PA 19106-0109**

5. You will receive an approval or a denial notice that is the same as other notices which are sent out for the approval or denial of a service.

## Dental Benefit Limitations

<b>Dental Coverage Limitations By Program</b>		
<b>Procedure Service</b>	<b>Common ADA Codes</b>	<b>Program Coverage</b>
Periodic Oral Exam	D0120	<p>For clients &lt;21 years of age-Limited to one per client per 6 month period.</p> <p>For clients 21 years of age or older-Limit to one per client per 12 month period.</p> <p><b>Effective September 1, 2014, D0120 is no longer payable for the following specialties: Endodontists, Oral &amp; Maxillofacial Radiologists, Oral &amp; Maxillofacial Pathologists, Anesthesiologists, Oral Surgeons, Orthodontists, and Hygienists</b></p> <p><b>Note:</b> When a client has a chronic medical condition (examples include but are not limited to uncontrolled diabetes, organ transplant or is taking an anti – seizure medication) 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 twelve (12) month period, an additional periodic oral examination may be requested through the established prior authorization process. The prior authorization request must include a description and/or documentation that will justify the medical necessity for the additional examination.</p> <p><b>-No HUSKY B Copay</b></p> <p><b>- Source: Provider Bulletin 2011-61, 2014-62 &amp; chapter 7 of the CT DSS Dental Provider Manual</b></p>
Emergency or Limited Oral Exam	D0140	<p>Effective September 1, 2014, both children and adults are eligible for only four (4) problem focused exams per calendar year</p> <p><b>-No HUSKY B Copay</b></p> <p><b>-Source: Provider Bulletin 2014-62 and Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Comprehensive Oral Exam	D0150	<p>For clients &lt;21 years of age-One per 36 months.</p> <p>For clients 21 years of age or older-Limit to one per client per lifetime.</p> <p><b>Note:</b> When a client changes providers, an additional comprehensive examination service can be requested through the established prior authorization process.</p> <p><b>-No HUSKY B Copay</b></p>

		Source: Provider Bulletin 2011-61 & chapter 7 of the CT DSS Dental Provider Manual
Detailed & Extensive Oral Evaluation	D0160	- <b>No HUSKY B Copay</b> - <b>Source: HP/EDS Fee schedule &amp; Chapter 7 of the CT DSS Dental Provider Manual</b>
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.  <b>Note:</b> Under the HUSKY dental plan, a panoramic or a full mouth series is covered under the plan 1X per 36 months.  - <b>No HUSKY B Copay</b>  - <b>Source: Chapter 7 of the CT DSS Dental Provider Manual</b>
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 monthly frequency restriction for clients <21 years of age.) (Any X-Ray in addition to 4 Periapical requires PA.) 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. - <b>No HUSKY B Copay</b>  - <b>Source: Provider Bulletin 2011-61 &amp; chapter 7 of the CT DSS Dental Provider Manual</b>
X-Ray-Bitewing	D0270-Single D0272-Two D0274-four	Effective May 1, 2015, clients of all ages are limited to 1 bitewing procedure (D0270, D0272 or D0274) per calendar year. (Any X-Rays in addition to bitewings & 3 periapicals requires a PA) - <b>No HUSKY B Copay</b>  - <b>Source: Provider Bulletin 2011-61, 2015-27 &amp; Chapter 7 of the CT DSS Dental Provider Manual</b>
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

		<p>maxillofacial surgeons and orthodontists.</p> <p>Note: Under the HUSKY dental plan, either a panoramic X-ray or a full mouth series is covered under the plan 1X per 36 months.</p> <p>When a client has a documented need that warrants a panoramic radiograph, the service can be requested through the prior authorization process.</p> <p><b>-No HUSKY B Copay</b></p> <p><b>- Source: Provider Bulletin 2011-61, Chapter 6 in the CTDHP Provider Manual &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Caries Susceptibility Screening	D0425	<p>Prior Authorization is required for the specialties that are allowed to bill for this procedure.</p> <p>When submitting a PA, providers should include a description of the patient’s condition, why the screening should be done, and should also note how the results of the screening will influence future treatment.</p> <p>Providers should follow the EPSDT guidelines in the provider manual.</p> <p><b>-No HUSKY B Copay</b> <b>-Source Provider Bulletin 2014-62</b></p>
Caries Risk Assessment	D0601-Low Risk D0602-Moderate Risk D0603-High Risk	<p>Effective September 1, 2014 Payment for D0601, D0602 and D0603 will be limited to once per 6 months for children under the age of 21 years. Only dental hygienists, who are enrolled as a rendering provider in the CTDHP/HUSKY Health program, practicing in public health settings and who have completed calibration training will be eligible to receive reimbursement.</p> <p><b>-No HUSKY B Copay</b> <b>-Source: Provider bulletin 2014-62</b></p>
Dental Prophylaxis “Prophy”	D1110 Adult D1120 Pediatric	<p>For clients &lt;21 years of age-Limited to one per client per 6 month period.</p> <p>For clients 21 years of age or older-Limit to one per client per 12 month period.</p> <p><b>Note:</b> includes cleaning, supra &amp; sub gingival scaling &amp; polishing.</p> <p>When a client has a chronic medical condition (examples include but are not limited to uncontrolled diabetes, organ transplant or is taking an anti – seizure medication) 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</p>

		<p>adult age 21 and over, an additional prophylaxis can 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 procedure.</p> <p><b>Effective June 15<sup>th</sup>, 2013, CTDHP will no longer accept or process prior authorization requests for D1110 without a date of service. <u>Submissions for these procedures will be processed on a post-procedure review basis only.</u></b></p> <p><b>-No HUSKY B Copay</b>  <b>- Source: Provider Bulletin 2011-61, fee schedule &amp; chapter 7 of the CT DSS Dental Provider Manual</b></p>
Topical Application of Fluoride-Child	D1203-Topical Fluoride	<p>No longer covered under the HUSKY dental plan as of 01/01/2013. Replaced by D1208</p> <p><b>- Source: HP/EDS Fee Schedule &amp; 2013 CDT Update</b></p>
Topical Application of Fluoride- Adult	D1204-Topical fluoride	<p>No longer covered under the HUSKY dental plan as of 01/01/2013. Replaced by D1208</p> <p><b>- Source: HP/EDS Fee Schedule &amp; 2013 CDT Update</b></p>
Topical Fluoride Varnish-Therapeutic Application	D1206-Topical Fluoride Varnish- Child or Adult	<p>No longer covered under the HUSKY dental plan as of 01/01/2013. Covered only when billed under HUSKY medical benefit</p> <p><b>- Source: HP/EDS Fee Schedule &amp; 2013 CDT Update</b></p>
Topical Application of Fluoride-Adult & Children	D1208-Topical Fluoride application	<p>For clients less than 21 years of age-Limited to no more than twice (at 6 month intervals) per client per year.</p> <p>For clients 21 years of age or older-Limited to those who have xerostomia or have undergone head and/or neck radiation therapy and requires PA.</p> <p><b>-No HUSKY B Copay</b></p> <p><b>- Source: HP/EDS Fee Schedule, 2013 CDT update &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Tobacco Counseling	D1320	<p><b>Effective September 1, 2014 chart documentation required for this code.</b></p> <p>The client's chart must confirm that the client uses tobacco products and cite the form (i.e. smoking, chewing, or holds in vestibule), the quantity used in a 24 hour period, and type of counseling provided (oral, written, and/or referral). All charts must be signed and dated on the date of service.</p> <p><b>-No HUSKY B Copay</b>  <b>-Source: Provider Bulletin 2014-62</b></p>

Pit & Fissure Sealants	D1351	<p>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</p> <p><b>-No HUSKY B Copay</b> <b>- Source: Provider Bulletin Provider Bulletin 06-103, 09-25 &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Space Maintainers	<p>D1510-Fixed Unilateral</p> <p>D1515-Fixed Bilateral</p> <p>D1525-Removable Bilateral</p>	<p>D1510 – limit of 4 covered Prior Authorization Required for some specialties</p> <p>D1515 – limit of 2 covered Prior Authorization Required for some specialties</p> <p>D1525 – limit of 2 covered Prior Authorization Required for some specialties</p> <p><b>- Source: HP/EDS Fee Schedule &amp; Chapter 7 of the CT DSS Dental Provider Manual</b> <b>HUSKY B Copay-33%</b></p>
Recementation of Space Maintainer	D1550	<p>Covered Prior Authorization required for some specialties <b>HUSKY B Copay-20%</b></p> <p><b>- Source: HP/EDS Fee Schedule &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Removal of Fixed Space Maintainer	D1555	<p>Covered Prior Authorization Required for some specialties <b>HUSKY B Copay-33%</b></p> <p><b>- Source: HP/EDS Fee Schedule &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Restorations-Fillings- Amalgams (Metal)  (1-32, A-T)	<p>D2140 – 1 surface</p> <p>D2150 – 2 surface</p> <p>D2160 – 3 surface</p> <p>D2161 – 4 surface</p>	<p>Once per year to same surface -no primary teeth which are about to come out. <b><i>Effective October 1, 2014, tooth surface B (buccal) and F (facial) will no longer be allowed to be billed in conjunction with each other for the same procedure code and tooth number.</i></b></p> <p><b><i>Effective October 1, 2014, Dental providers will be reimbursed for the total number of surfaces restored on a single tooth per one year period per provider. The same surface even billed in</i></b></p>



		<p><i>conjunction with a different surface will not be covered in that same one year period.</i></p> <p><b>HUSKY B Copay-20%</b>  <b>- Source: Provider Bulletin 2009-25, 2014-62 &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Restorations-Fillings-Composite Resin (White)	<p>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 &amp; 32 are not covered.)</p>	<p>Once per year to same surface by same provider-no primary teeth which are about to come out.</p> <p>For clients 21 years of age or older-Posterior composite resin restorations D2391, D2392, D2393 &amp; D2394 are no longer a covered procedure for first molar teeth (3, 14, 19 &amp; 30) and second molar teeth (2, 15, 18, &amp; 31).</p> <p><b><i>Effective October 1, 2014, tooth surface B (buccal) and F (facial) will no longer be allowed to be billed in conjunction with each other for the same procedure code and tooth number.</i></b></p> <p><b><i>Effective October 1, 2014, Dental providers will be reimbursed for the total number of surfaces restored on a single tooth per one year period per provider. The same surface even billed in conjunction with a different surface will not be covered in that same one year period.</i></b></p> <p><b>HUSKY B-20% Copay</b></p> <p><b>- Source: Provider Bulletin 2009-25, Provider Bulletin 2009-57, Provider Bulletin 2011-61, Bulletin 2014-62 &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Crown –Porcelain fused to predominantly base metal (Anterior permanent teeth #4-13 & 20-29 only.) (predominantly shows porcelain)	D2751 - Anterior	<p>Crown – Porcelain fused to predominantly base metal – Anterior Teeth</p> <p>Once per five year limitation</p> <p>PA Required</p> <p>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.</p> <p>PA submissions must include mounted pre-operative periapical, Pan or FMX (no bitewings) &amp; complete charting of client’s dentition including any planned extractions.</p> <p><b>HUSKY B Copay 33%</b>  <b>- Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual &amp; CTDHP Provider Manual Chapter 6</b></p>

<p>Crown-Full cast predominantly base metal (Permanent Teeth #1-32) (predominantly shows metal)</p>	<p>D2791</p>	<p>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) &amp; complete charting of client’s dentition including any planned extractions.</p> <p><b>HUSKY B Copay 33%</b> - Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual &amp; CTDHP Provider Manual Chapter 6</p>
<p>Re-cement Crown</p>	<p>D2910 D2920</p>	<p><b>HUSKY B Copay 20%</b> - Source: Provider Bulletin 09-25 &amp; Chapter 7 of the CT DSS Dental Provider Manual</p>
<p>Crowns-Stainless Steel with Resin Window (Primarily used on children)</p>	<p>D2930-Primary D2931-Permanent D2933-Primary or Permanent (<b>No longer Covered</b>) D2934 – Primary or Permanent (replaces D2933)</p>	<p>D2930 – Prior Authorization required for some specialties D2931 – Prior Authorization required for some specialties D2933 – Prior Authorization required for some specialties Covered only when breakdown of tooth structure is excessive D2933 No longer covered, effective September 1, 2014 D2934 Covered for primary or permanent teeth, Anterior or Posterior</p> <p>Crowns are not covered for primary teeth which are about to come out.</p> <p><b>HUSKY B Copay 33%</b> - Source: Provider Bulletin 2009-25, 2014-62 &amp; Chapter 7 of the CT DSS Dental Provider Manual</p>
<p>Restorative Temporary Sedative filling</p>	<p>D2940</p>	<p>Prior Authorization required for some specialties</p> <p><b>HUSKY B Copay 20%</b> - Source: Provider Bulletin 09-25 &amp; Chapter 7 of the CT DSS Dental Provider Manual</p>
<p>Core Buildup</p>	<p>D2950</p>	<p>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</p>

		<p>longevity is essential for the tooth in treatment and can demonstrate at least a supportable five year positive prognosis. Posts &amp; cores are to be used solely on endodontic 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.</p> <p>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.</p> <p>Prior Authorization required</p> <p><b>HUSKY B Copay 33%</b>  <b>- Source: Provider Bulletin 09-25 &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Pin Retention-per Tooth In Addition To	D2951	<p><b>HUSKY B Copay 33%</b>  <b>- Source: Provider Bulletin 09-25 &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Pulp Cap, Direct	D3110	<p><b>Effective September 1, 2014, this procedure is restricted to members under the age of twenty-one.</b></p> <p><b>-HUSKY B Copay 20%</b>  <b>-Source: Provider Bulletin 2014-62</b></p>
Endodontic Therapy – Anterior Teeth (#6-11 or 22-27) PA is required for 21 & over	D3310 - Anterior	<p>Once per tooth per Client per lifetime limitation  PA/PR is required for all ages  PA submissions must include mounted pre-operative periapical, Pan or FMX (no bitewings) &amp; complete charting of client’s dentition including any planned extractions.</p> <p><b>HUSKY B Copay 20%</b>  <b>- Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual &amp; CTDHP Provider Manual Chapter 6</b></p>
Endodontic Therapy – Posterior Teeth (# 1-5, 12-16, 17-21, 28-32) PA is required for 21 & over	D3320 - Bicuspid D3330 - Molar	<p>Once per tooth per Client per lifetime limitation.  PA/PR is required for all ages  PA submissions must include mounted pre-operative periapical, Pan or FMX (no bitewings) &amp; complete charting of client’s dentition including any planned extractions.</p> <p><b>HUSKY B Copay 20%</b>  <b>- Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual &amp; CTDHP Provider Manual Chapter 6</b></p>

Retreatment Root Canal Therapy	D3346-Anterior D3347-Premolar/Bicuspid D3348-Posterior/Molar	Covered for ages 0-20. PA required for all providers except Endodontists <b>HUSKY B Copay 20%</b>  - <b>Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual</b>
Apicoectomy/ Periraduclar Surgery	D3410-Anterior D3421-Bicuspid D3425-Molar	PA is required for under age 21. Endodontists do not require PA for these procedures. <b>HUSKY B Copay 20%</b>  - <b>Source: Provider Bulletin 09-25, &amp; Chapter 7 of the CT DSS Dental Provider Manual</b>
Apexification	D3351 – Initial Visit D3352 – Interim Visit D3353 – Final Visit	Restricted to ages 0-17. PA is required for all specialties except Endodontists. <b>HUSKY B Copay 20%</b>  - <b>Source: Provider Bulletin 09-25, 2014-62 &amp; Chapter 7 of the CT DSS Dental Provider Manual</b>
Gingevectomy or Gingivoplasty (Reposition forming tooth bud to another socket)	D4210-Four or More Teeth D4211-One to Three Teeth	PA required for 21 & over  <b>HUSKY B Copay 50%</b>  - <b>Source: Chapter 7 of the CT DSS Dental Provider Manual</b>
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. <b>Note:</b> 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. 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

		<p>not be replaced for cosmetic reasons.</p> <p><b>HUSKY B Copay 50%</b>  <b>- Source: Provider Bulletin 11-61, AB Letter effective July 1, 2011 &amp; CTDHP Provider Manual chapter 6</b></p>
Removable Prosthetic – Partial Denture (Requires PA)	<p>5211 Partial Upper Resin Based</p> <p>5212 Partial Lower Resin Based</p> <p>5213-Partial Upper Cast metal</p> <p>5214-Partial Lower Cast metal</p>	<p>Covered once per 7 year period limitation.</p> <p>Denture labeling covered for patients in long term care facilities.</p> <p><b>Note:</b> 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.</p> <p>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.</p> <p>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. 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.</p> <p><b>HUSKY B-50% Copay</b>  <b>- Source: Provider Bulletin 11-61, AB Letter effective July 1, 2011 &amp; CTDHP Provider Manual chapter 6</b></p>
Denture Repairs	<p>D5510-Repair of Broken Complete Denture Base</p> <p>D5520-Replace Missing or Broken Teeth-Complete</p> <p>D5610-Repair Resin Denture Base</p> <p>D5620-Repair Cast</p>	<p><b>HUSKY B Copay 20%</b></p> <p><b>- Source: Provider Bulletin 09-25 &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>

	<p>Framework</p> <p>D5640-Repair or Replace Broken Clasp</p> <p>D5650-Add Tooth to Existing Partial Denture</p> <p>D5660-Add Clasp to Existing Partial Denture</p>	
Reline Dentures - Chairside	<p>D5730-Reline Complete Maxillary Denture-Chair side</p> <p>D5731-Reline Complete Mandibular Denture-Chairside</p> <p>D5740-Reline Maxillary Partial Denture-Chair side</p> <p>D5741-Reline Mandibular Partial Denture – Chairside</p>	<p>Once per 2 year period limitation</p> <p>PA Required for some specialties</p> <p>HUSKY B Copay-20%</p> <p>- Source: Chapter 7 of the CT DSS Dental Provider Manual</p>
Reline Dentures - Laboratory	<p>D5750- Reline Complete Maxillary Denture</p> <p>D5751- Reline Complete Mandibular Denture</p> <p>D5760- Reline Maxillary Partial Denture</p> <p>D5761- Reline Mandibular Partial Denture</p>	<p>Once per 2 year period limitation</p> <p>Prior Authorization required for some specialties</p> <p><b>HUSKY B Copay 20%</b></p> <p>- Source: Provider Bulletin 11-07, &amp; Chapter 7 of the CT DSS Dental Provider Manual</p>
Obturator Prosthesis	D5931-Surgical	<p><b>HUSKY B Copay 20%</b></p> <p>- Source: Provider Bulletin 09-25, &amp; Chapter 7 of the CT DSS Dental Provider Manual</p>
Obturator Prosthesis	D5932-Definitive	<b>HUSKY B Copay 20%</b>
Fluoride Carrier	D5986	<b>Effective September 1, 2014, PA required for non-pediatric dentists. No age restriction applies.</b>

		-No HUSKY B Copay -Source: Provider Bulletin 2014-62
<b>Oral Surgery Limitations:</b> Only Sutures of lacerations of mouth in accident cases only & not cases incidental to and connected with dental surgery. Gingivectomy only for severe side effects caused by medication. Only replant avulsed anterior tooth, not in conjunction with a root canal. Only bone grafts, mandible, restricted to the replacement of bone previously removed by radical surgery procedure.		
Simple Exodontias (Extractions)	D7140 – Extraction of erupted tooth or exposed root	Covered for all permanent, primary and supernumerary teeth <b>20% HUSKY B Copay</b>  - Source: Provider Bulletin 09-25, & Chapter 7 of the CT DSS Dental Provider Manual
Surgical Exodontias (Extractions)	D7210 - Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth	Covered for all permanent, primary and supernumerary teeth <b>33% HUSKY B Copay</b> <i>(Oral Surgeons are not required to submit PA for surgical extractions)</i>  - Source: Provider Bulletin 09-25, & Chapter 7 of the CT DSS Dental Provider Manual
Impactions	D7220-Soft Tissue D7230-Partially Bony D7240-Completely Bony D7241-Completely Bony, with unusual surgical complications	Elective Impactions require special consideration & X-Rays supporting the need for service. PA Required <b>HUSKY B Copay 33%</b>  - Source: Provider Bulletin 09-25 & Chapter 7 of the CT DSS Dental Provider Manual
Tooth Transplantation	D7272	Restricted to ages 0-20  <b>HUSKY B Copay 20%</b>  - Source: Provider Bulletin 09-25 & Chapter 7 of the CT DSS Dental Provider Manual
Surgical Access of Unerupted Tooth for orthodontia	D7280	Restricted to ages 0-20 <b>HUSKY B Copay 20%</b>  - Source: Provider Bulletin 09-25 & Chapter 7 of the CT DSS Dental Provider Manual

Placement of device to facilitate eruption of impacted tooth	D7283	Restricted to ages 0-20 <b>No HUSKY B Copay</b>	
Osteoplasty	D7940 D7941 D7944 D7945	Requires PA <b>HUSKY B Copay 20%</b>  <i>- Source: Chapter 7 of the CT DSS Dental Provider Manual</i>	
Closure of Salivary Fistula	D7983	<b>HUSKY B Copay 20%</b>  <i>- Source: Provider Bulletin 09-25, &amp; Chapter 7 of the CT DSS Dental Provider Manual</i>	
Orthodontics  (Required PA)	D8000-8999  D8660-Pre-Orthodontic Treatment D8670-Periodic Orthodontic Treatment D8692-Replacement of Orthodontic Retainer D8999-Unspecified Orthodontic Treatment	<b>HUSKY A, HUSKY C, HUSKY D</b> 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 by the age of 21. Prior Authorization required.  Orthodontic treatment must be medically necessary and authorized if one of the following conditions are met: <ul style="list-style-type: none"> <li>• The client obtains 24 or more points on a correctly scored Malocclusion Severity Assessment; or:</li> <li>• 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/psychiatrist or:</li> <li>• The client presents</li> </ul>	<b>HUSKY B</b> Once per client per lifetime. Active treatment-max of 30 months per recipient Work must be qualified Orthodontist Limited to recipients under age 19 No predetermination required Benefit limited to \$725.00 per case Client is responsible for balance up to 3410.00  <i>- Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual, CTDHP Provider Manual chapter 6</i>



		<p>evidence of a severe deviation affecting the mouth and /or underlying structures.</p> <p>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.</p> <p>30 visits max / \$3410 total</p> <p><b>-Source: Provider Bulletin 09-25, Chapter 7 of the CT DSS Dental Provider Manual, CTDHP Provider Manual chapter 6</b></p>	
Local Anesthesia		It is not payable as a separate service & is included in other procedure codes.	
General Surgical Anesthesia	<p>D9220-Deep Sedation/General Anesthesia-first 30 minutes</p> <p>D9221- Deep Sedation/ General Anesthesia-each additional 15 minutes</p>	<p>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.</p> <p>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.</p> <p><b><i>Not a covered benefit for clients age nine (9) or over for the extraction of a single tooth or general dental services.</i></b></p> <p><b><i>Not a covered benefit for clients twenty one or over for the extraction</i></b></p>	

		<p><i>of less than six (6) single teeth-excluding third molars or for general dental treatment</i></p> <p><b>HUSKY B Copay is 20%</b></p> <p><b>- Source: Chapter 6 of CTDHP Provider Manual</b></p>
Analgesia, Anxiolysis, Inhalation of Nitrous Oxide “Laughing Gas”	D9230 –Analgesia, Anxiolysis Inhalation NO2	<p>Covered for clients under the age of nine (prior to ninth birthday), or clients of any age who have a <b>diagnosis such as</b> autism, cerebral palsy hyperactivity disorder or developmental delay with a demonstrated need for behavior management related to the dental procedures to be performed.</p> <p>Nitrous covered for children up to age nine or of any age that has diagnosis of autism, hyperactivity disorder or severe/profound developmental delay with a demonstrated need for behavior management related to the dental procedures to be performed.</p> <p><b><i>Not a covered benefit for clients age nine (9) or over for the extraction of a single tooth or general dental services.</i></b></p> <p><b><i>Not a covered benefit for clients twenty one or over for general dental services.</i></b></p> <p><b>HUSKY B Copay 20%</b></p> <p><b>- Source: Chapter 6 of CTDHP Provider Manual</b></p>
Intravenous Conscious Sedation	<p>D9241-Intravenous Conscious Sedation/ Analgesia -first 30 minutes</p> <p>D9242- Intravenous Conscious Sedation/Analgesia - each additional 15 minutes</p>	<p>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.</p> <p>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.</p> <p><b><i>Not a covered benefit for clients age nine (9) or over for the extraction of a single tooth or general dental services.</i></b></p> <p><b><i>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</i></b></p>

		<p><b>HUSKY B Copay 20%</b></p> <p><b>- Source: Chapter 6 of CTDHP Provider Manual</b></p>
House/Extended Care Facility/Hospital Call	D9410- House/Extended Care Facility Call D9420-Hospital Call	<p>The House/Extended Care facility call is limited to <u>only private practice dentists and public health hygienists</u> (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.</p> <p><b>-No HUSKY B Copay</b></p> <p><b>- Source: Provider Bulletin 11-61</b></p>
Patient Management	D9920	<p>Prior Authorization Required</p> <p>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.</p> <p>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 DMR attesting the authenticity of diagnosis.</p> <p><b>HUSKY B Copay is 20%</b></p> <p><b>- Source: Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Occlusal “Night” Guards (By Report)	D9940  D9999-1 Additional FQHC Encounter Code	<p>Covered By Report</p> <p>Prior Authorization required for patients 21 years of age and older</p> <p><b>HUSKY B Copay-20%</b></p> <p><b>- Source: HP/EDS Fee Schedule &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Fabrication of Athletic Mouth Guard	D9941	<p>Covered for patients up to age 20</p> <p>Prior Authorization required</p> <p><b>HUSKY B Copay-20%</b></p> <p><b>- Source: HP/EDS Fee Schedule &amp; Chapter 7 of the CT DSS Dental Provider Manual</b></p>
Periodontia	D4000 – D4999	<b>Not covered</b>
Implants	D6000 – D6199	<b>Not covered</b>
Cosmetic Dentistry		<b>Not covered</b>
Vestibuloplasty	D7340, D7350	<b>Not covered</b>
Canceled or Missed appointments		<p><b>Not covered</b> - Providers cannot charge clients for cancelled or missed appointments.</p> <p><b>Source: Provider Bulletin 2015-5</b></p>



## Orthodontic Services: Regulations and Procedures

### Orthodontic Case Review Standards and Guidelines

With the exception of HUSKY B clients, all orthodontic cases require prior authorization based upon the criteria established by the Department of Social Services Medical Services Policies, Dental Services: 184F.I.c.1 and/or the definition of medical necessity contained in 42 U.S.C. 1396d(r)(3)(B). Under the standard set forth by the State of Connecticut, orthodontic treatment is authorized as medically necessary if one of the following conditions is 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, and or behavioral condition associated with the client's dental condition; or
- The client presents evidence of a severe deviation affecting the mouth and/or underlying dentofacial 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 those provisions, orthodontia is approved if medically necessary for the relief of pain or infection, restoration of teeth, or maintenance of dental health.

Although Prior Authorization is not required for HUSKY B Clients, you should complete and retain documentation in your charts which supports the criteria shown above as having been met.

### Orthodontic Case Processing

Monthly remittances for your approved HUSKY A and Medicaid orthodontic cases, **for which patients remain eligible**, will be automated and you will not be required to submit claims on a monthly basis. Payments and remittance advice will be made by HP Enterprises, after the receipt and processing of monthly transactions which will be submitted on your behalf by BeneCare. Typically, the claims are submitted on the second claims cycle of each month.

HUSKY A and Fee-for-Service Traditional Medicaid total orthodontic case fees are \$3,410.00 and will be comprised of the following:

- One (1) initial payment for Comprehensive Orthodontic Treatment (D8080) of \$596.23
- Thirty (30) monthly payments for Periodic Orthodontic Treatment Visits (D8670) of \$93.80

HUSKY B orthodontic case fees will be made in one lump sum of \$725.00 under Comprehensive Orthodontic Treatment (D8080).

Additionally, approved orthodontic cases will be entitled to reimbursement for diagnostic and records procedures if those services are submitted in conjunction with the original pre-approval submission or the claim detailing the insertion of orthodontic appliance(s). The following procedures will be included with each case's initial remittance if they are submitted:

- Panoramic Film (D0330) - \$87.00
- Diagnostic Casts (D0470) - \$98.00
- Pre-orthodontic Visit (D8660) - \$34.32

The total reimbursement for thirty months of Comprehensive Orthodontic Treatment under the HUSKY A and HUSKY C (Fee-For-Service Medicaid) programs, including all diagnostic and records procedures, is \$3,629.55.

Please note you must be an actively enrolled provider with the Department, through HP Enterprises, before BeneCare can approve or transmit your approved orthodontic case claim for payment. If you are not currently enrolled with the Department through HP Enterprises or have questions about your enrollment status, please contact our Network Development Manager, Michael Massarelli at (860)507-2303.

Prior approval is required for HUSKY A and C cases that were already under active treatment at the time the client became eligible. The client must have met the current standards outlined in regulation before having commenced with their orthodontic therapy. Clients are responsible for contacting their previous orthodontist and having their records sent to your office.

In circumstances where a HUSKY B client becomes eligible under HUSKY A or HUSKY C, their orthodontic case will be continued and amended so that it is paid up to the HUSKY A total case fee less the \$725.00 HUSKY B payment and over the number of treatment months remaining.

Likewise, when a client becomes eligible under HUSKY A or HUSKY C programs and is currently under active orthodontic treatment, their case will be assumed and paid for the number of months of treatments remaining at the monthly rate in effect at the time. In situations where patients lose eligibility and subsequently regain their eligibility at a later time, and those patients remained in active treatment during their interval of ineligibility, their orthodontic cases will be restarted and monthly remittances made necessary to bring the total payments concurrent with their course of treatment. In

the event a client is made retroactively eligible during a lag time during the re – enrollment process, the months where treatment was given will also be billed to HP Enterprises on your behalf.

## **Orthodontic Case Submissions**

Cases may be submitted electronically at [www.ctdhp.com](http://www.ctdhp.com) (see chapter 6 for specific instructions) or submit your paper/hard copy orthodontic cases for review to:

**Orthodontic Case Review  
C/O BeneCare Dental Plans  
195 Scott Swamp Road, Suite 101  
Farmington, CT 06032**

Your orthodontic case submissions **must** include the following:

1. A standard ADA or similar claim form detailing:
  - a. Client's name as it appears on their grey CONNECT card
  - b. Client's Medicaid ID number as it appears on the CONNECT card
  - c. Dentist's name and name of facility if applicable
  - d. NPI, TIN and SSN identifiers as appropriate
  - e. Standard ADA CDT procedure code(s)
  - f. Description of procedure in English
  - g. Doctor's usual and customary fee(s)
  - h. Any other pertinent insurance coverage information
2. Properly trimmed study models
3. A properly completed and scored Salzmann Malocclusion Severity Assessment form
4. A panoramic X-ray
5. Additional documentation from referring general dentists, pediatric behavioral health or mental health providers, or a statement that no other documentation was presented
6. A narrative description of any severe deviation(s) affecting the mouth and/or underlying structures that would not be evident from the diagnostic materials provided

Cases submitted for review without the documentation listed above will be returned to the submitting office. A sample return form is shown below:

## Orthodontic Information Request Form

Client: \_\_\_\_\_ ID#: \_\_\_\_\_

Claim #: \_\_\_\_\_ Date: \_\_\_\_\_

Dear Doctor:

Your request for review of orthodontic services for your patient is incomplete as submitted or, in the opinion of the program's dental consultant(s) does not appear to be consistent with the criteria of the Connecticut Medical Assistance Program. To allow proper processing of your request, we are returning your submission and supporting documentation for the following reasons:

- Client's name as it appears on their grey CONNECT card is required
- Client's Medicaid ID number as it appears on their grey CONNECT card is required
- Dentist's NPI, TIN and/or SSN identifiers are required on the accompanying claim form
- Panoramic radiograph or full X-ray series is required
- Properly completed and scored Malocclusion Severity Assessment, including Section G on Other Deviations (sample form enclosed) is required
- Diagnostic casts (models) must be properly trimmed
- Radiographs and/or models must be of diagnostic quality
- Properly labeled/identified radiographs and/or models are required
- Other \_\_\_\_\_

Please resubmit this request with the missing or corrected information and/or materials for further consideration.

- Interceptive treatment is not a Medicaid covered service: patient has mixed dentition and no documentation from referring general dentists, behavioral health or mental health providers, or other severe deviations affecting mouth and/or underlying structures are present as noted in section G.

Please discuss monitoring, future orthodontic therapy, and alternative treatment options with your patient at this time.



## **Malocclusion Severity Assessment Scoring Guidelines**

The following references correspond to the sample Salzmann Scoring Sheet which follows this section.

### **SECTION E. Intra Arch Deviation**

- Only the four maxillary incisors should be included in this category. Additionally, the maximum score for this line cannot exceed eight (8) points, and no tooth may be scored twice, such as counting a tooth as both crowded and rotated.
- Only the four mandibular incisors should be included in this category. Additionally the maximum score for this line cannot exceed four (4) points, and no tooth may be scored twice, such as counting a tooth as both crowded and rotated.
- Rotation in the posterior area only refers to tooth irregularities that interrupt the continuity of the dental arch and involve all or part of the lingual or buccal surfaces such that rotated posterior teeth have buccal or lingual surface(s) wholly or partially facing the proximal surface of adjacent teeth.

### **SECTION F. Inter Arch Deviation**

- Overjet only refers to those maxillary incisors that have a labio axial inclination with mandibular incisors occluding the palatal gingivae.
- Overbite only refers to those maxillary incisors that occlude on or opposite the mandibular labial gingivae or those mandibular incisors that occlude on the palatal gingivae.

### **SECTION 2. Posterior Segments**

- Mesio-distal deviation only refers to the mandibular teeth that have their buccal cusps (mesio buccal cusp of the first permanent molar) occluding entirely mesial or distal to the accepted normal relation to the maxillary teeth.
- Posterior crossbite only refers to the maxillary posterior teeth that are buccally or lingually displaced out of the entire occlusal contact with the opposing arch.

Closed Spacing means space insufficient for the complete eruption of a tooth.

Only permanent teeth may be counted when completing the malocclusion assessment record for the determination of medical necessity. By definition, interceptive therapy is not a covered service unless it is needed to prevent a skeletal abnormal developmental condition.

Member Name: \_\_\_\_\_ ID#: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

**PRELIMINARY HANDICAPPING MALOCCLUSION ASSESSMENT RECORD  
EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM**  
(Part III: Sections "E", "F" and "G" are completed by the orthodontist.  
Please mark the affected tooth numbers.)

**E. INTRA-ARCH DEVIATION**

SCORE TEETH AFFECTED ONLY		MISSING	CROWDED	ROTATED	SPACING		NO.	POINT VALUE	SCORE
					OPEN	CLOSED			
MAXILLA	Ant	7 8 9 10	7 8 9 10	7 8 9 10	7 8 9 10	7 8 9 10		X 2	
	Post	3 4 5 6 14 13 12 11	3 4 5 6 14 13 12 11	3 4 5 6 14 13 12 11	3 4 5 6 14 13 12 11	3 4 5 6 14 13 12 11		X 1	
MANDIBLE	Ant	23 24 25 26	23 24 25 26	23 24 25 26	23 24 25 26	23 24 25 26		X 1	
	Post	19 20 21 22 30 29 28 27	19 20 21 22 30 29 28 27	19 20 21 22 30 29 28 27	19 20 21 22 30 29 28 27	19 20 21 22 30 29 28 27		X 1	
TOTAL SCORE									

Ant = anterior teeth (4 incisors). Post = posterior teeth (including canine, premolars, and first molar). No. = number of teeth affected.

**F. INTER-ARCH DEVIATION**

**1. Anterior Segment**

SCORE MAXILLARY TEETH AFFECTED ONLY EXCEPT OVERBITE*	OVERJET	OVERBITE(MAX 4 TEETH)	CROSSBITE	OPENBITE	NO.	POINT VALUE	SCORE	
	7 8 9 10	7 8 9 10 23 24 25 26	7 8 9 10 23 24 25 26	7 8 9 10				7 8 9 10
TOTAL SCORE								

\*Score maxillary or mandibular incisors. No. = number of teeth affected.

**2. Posterior Segments**

SCORE TEETH AFFECTED ONLY	RELATE MANDIBULAR TO MAXILLARY TEETH				SCORE AFFECTED MAXILLARY TEETH ONLY				NO.	POINT VALUE	SCORE
	DISTAL		MESIAL		CROSSBITE		OPENBITE				
	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT			
Canine										X 1	
1 <sup>st</sup> Premolar										X 1	
2 <sup>nd</sup> Premolar										X 1	
1 <sup>st</sup> Molar										X 1	
TOTAL SCORE											
GRAND TOTAL											

**G. OTHER DEVIATIONS (use additional sheet if necessary)**

If the total score is less than twenty-four (24) points the Department shall consider additional information of a substantial nature about the presence of other severe deviations affecting the mouth and underlying structures. Other deviations shall be considered severe if, left untreated; they would cause irreversible damage to the teeth and underlying structures.

Is there presence of other severe deviations affecting the mouth and underlying structures? (If any, comment below).  Y /  N

Records Submitted:  FMS  Panorex  Models  Photographs  Clads  Other: \_\_\_\_\_

Date of Records: \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

ASSESSMENT RECORD Prepared by:

\_\_\_\_\_  
 Signature Date

Please submit your completed Assessment ,Diagnostic materials, and Claim form to:  
 Orthodontic Case review:  
 C/O CT Dental Health Partnership  
 195 Scott Swamp Rd  
 Farmington, CT 06032

**Sample Salzmann Scoring Sheet**

## **Frequently Asked Questions on Orthodontic Cases**

### **1. Are only stone models acceptable?**

It is preferable to receive stone models since they do not chip or fracture as easily during shipping as other types of models such as plaster. The models must be dry, properly trimmed, include a bite registration and be of diagnostic quality. Other material is accepted if you believe it is beneficial to the evaluation process.

### **2. Can you send only a photo?**

No, regulations state in order to evaluate a case for potential orthodontic therapy, the assessment record **MUST** include a Salzmänn Scoring Sheet, properly trimmed models with a bite registration, a radiograph, and other documentation such as photographs or a psychological assessment performed by a psychologist or psychiatrist certified as a child mental health care provider.

### **3. When scoring the Salzmänn Scoring Sheet, can a tooth be considered crowded and rotated?**

No, according to the Salzmänn Scoring instructions, a single tooth can only fall into one category. Therefore, the tooth has to be either considered crowded or rotated.

### **4. Are electronic models acceptable?**

Yes. At this time, we currently accept digital study models produced using emodel® from Geodigm Corporation. For more information on emodel® please go to [www.dentalmodels.com](http://www.dentalmodels.com) or contact Geodigm Corporation at 866-436-6335.

### **5. What happens if the orthodontic treatment takes less than the allowed 30 month time frame?**

All cases regardless of the length of treatment will be paid out based on a 30 month treatment plan. Cases which are completed prior to 30 months will receive a final balloon payment for the last date of service to equal what a 30 month treatment would have paid.

## **6. Can a client switch orthodontists?**

All patients are locked into one orthodontist for treatment. Rare exceptions will be made only in cases where circumstances beyond the client's/provider's control necessitate changing the orthodontist. Patients who elect to discontinue treatment will not be eligible for orthodontia provided by another orthodontist.

## **7. Why do models come back broken sometimes?**

Models will break in transit if they were created out of a soft plaster rather than a stone material, or if they have not been properly wrapped. This is true especially for the lower and upper anterior teeth respectively.

## **8. Who pays if the patient scores less than a 24 on the Salzmann index?**

If a patient scores less than 24 points on the Salzmann index, he or she will not be authorized for orthodontic therapy unless there is substantiated proof that there are psychological reasons or underlying skeletally developmental reasons that could cause future problems. Without approval for treatment, the patient would be responsible for the cost of treatment. The provider must document that treatment is not covered by the plan (denial notice) and the patient or their legal guardian is willing to accept financial responsibility.

## **9. If the client starts orthodontia on HUSKY and 6 months later is no longer eligible for the program, what happens to the payments?**

The orthodontist should set up an agreement with the responsible party if the client is no longer covered with the state. This is the same circumstance as if a patient had commercial insurance and was terminated from that insurance. The state will not pay for treatment for a client who is not eligible.

## **10. What happens if a client starts orthodontia on HUSKY A and 6 months later is no longer eligible under that program and becomes eligible under HUSKY B?**

The client will be benefitted up to \$725.00 (including the payments made while covered under HUSKY A) for treatment and the client is responsible for the balance at the prevailing Medicaid reimbursement rate.

**11. What happens if a client starts orthodontia on HUSKY B and six months later becomes eligible under HUSKY A?**

The client will then begin to be benefitted at the regular monthly rate for orthodontia.

**12. Who can an orthodontist call for assistance in finding an oral surgeon for a client with special needs?**

Call the Connecticut Dental Health Partnership at 866-420-2924 for assistance in locating an oral and maxillofacial surgeon.

**13. How much does HUSKY B pay for orthodontia?**

HUSKY B will pay \$725.00 for each client towards the cost of orthodontic services. The orthodontist must have the patient/responsible party sign the contract stating that the client's guardian accepts the responsibility for anything above and beyond the HUSKY B payment up to the state allowed fee for orthodontic therapy.

**14. Can a provider charge HUSKY clients for missed or broken appointments?**

No, Federal Medicaid policy does not allow providers to charge Medicaid clients a fee for broken appointments. In addition, missed appointments are not a distinct, reimbursable Medicaid service, but are considered a part of providers' overall cost of doing business. Please see bulletin **PB15-05** for complete information on this topic.

Providers are also not allowed to collect an up-front deposit that is retained in the event that the client breaks a scheduled appointment.

**15. What procedure is followed if a client has private insurance as well as HUSKY coverage?**

For any client that is under 21 years old, the state will pay the claim and recoup payment from the private insurance for their portion. The state is the payer of last resort (pays when all other avenues have been exhausted) and will only pay up to the state allowed amount less any payments made by a third party insurer.

**16. What can an office do if a client speaks a foreign language and the office does not have someone that can translate?**

The office has the option of obtaining a translator through AT&T, but it is the office's responsibility to pay the expense.

**17. What if a patient is hearing impaired or deaf?**

Upon request, the state will send someone from the Commission for the Deaf and Hearing Impaired to translate.

**18. What recourse is there for a patient who keeps breaking brackets?**

DSS does not pay for broken brackets. If the office policy is the same for all commercial and state patients and requires the patient to pay for broken brackets then **the provider must notify the patient of the policy prior to the start of treatment**. The patient and their parents/guardians should be advised BEFORE treatment is actually begun that any abuse of the orthodontic appliance may mean dismissal from treatment and the dental practice.

**19. What if the client has qualified for treatment, brackets are placed and the client becomes uncooperative? Can I dismiss the patient?**

Yes, if the client does not adhere to the office policy they can be dismissed for the practice by that provider. The provider should apply the office policy to commercial, private pay and Medicaid patients. Consult your malpractice insurance company for any specific requirements that may exist for dismissing a non-compliant patient.

## Adult Dental Benefits

Several changes to adult dental benefits went in to effect on July 1, 2011. The benefit limitations are applied on a rolling year basis; this means that a client will not be eligible for a restricted service if the client has received the service 365 days previous to the scheduled appointment. For example, if a client received a cleaning on February 23, 2011, they will not be eligible to receive another cleaning until February 24, 2012.

The changes are designed to reduce specific benefits while maintaining services that will prevent further disease, decrease emergency department use and continue the maintenance of appropriate oral health. The changes to adult benefits are as follows:

1. **Comprehensive Exam (D0150)** – The comprehensive examination code for clients age twenty – one (21) years of age and older is limited to one per client per lifetime. When a client changes providers, an additional comprehensive examination service can be requested through the established prior authorization process.
2. **Periodic Oral Exam (D0120)** – The periodic exam is limited to one time per twelve (12) month period for healthy clients age twenty – one (21) and older. When a client has a chronic medical condition (examples include but are not limited to uncontrolled diabetes, organ transplant or is taking an anti – seizure medication) which warrants a dental examination more than one time per twelve (12) month period, an additional periodic oral examination may be requested through the established prior authorization process. The prior authorization request must include a description and/or documentation that will justify the medical necessity for the additional examination. Clients who reside in a long term care facility may receive two periodic exams per (12) twelve month period. Prior authorization is not required for these clients.
3. **Prophylaxis, Adult (D1110)** – The prophylaxis procedure is limited to one time per twelve (12) month period for healthy clients who are twenty – one (21) years of age and older. The exception to this policy is for clients who reside in a long term care facility. These clients are eligible for two prophylaxis per year, without prior authorization being required.
4. **Topical Application of Fluoride (CDT code D1208)** – The application of fluoride to adult dentition is limited to clients age twenty – one (21) and older who have xerostomia or have undergone head and/or neck radiation therapy.
5. **Bitewing X-rays (CDT codes D0270, D0272 & D0274)** – Bitewing X-rays are a reimbursable procedure one time per twelve (12) month period for each client regardless of age.
6. **Periapical X-rays (D0220 & D0230)** – Periapical X-rays are limited to four (4) radiographs per twelve (12) month period for clients age twenty – one and older.
7. **Panoramic Radiograph (D0330)** – Panoramic X-ray for clients age twenty – one (21) and older, is a reimbursable procedure that requires prior authorization for all dental specialties and clinics except for oral and maxillofacial surgeons and orthodontists.

8. **Resin Based Composite Restorations, Posterior (D2391, D2392, D2393 & D2394)** – Posterior composite resin restorations are no longer a covered procedure for clients twenty – one (21) years of age and older for first molar teeth (3, 14, 19 & 30) and second molar teeth (2, 15, 18, & 31).
9. **Complete Denture and Removable Partial Dentures (D5110, D5120, D5211, D5212, 5213 & D5214)** – Denture prosthesis construction is limited to one time per each seven year period for clients twenty – one (21) years of age and older. 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 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 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. 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.
10. **House/Extended Facility Care Call (D9410)** – 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.

When a client has a chronic medical condition that warrants a dental service more than the defined limitations for each procedure, an additional service may be requested through the established prior authorization process. The prior authorization request must include a description and/or documentation that will justify the medical necessity for the additional requested service. All prior authorization requests can be submitted via the [www.ctdhp.com](http://www.ctdhp.com) website or via hard copy to:

**CT Medicaid Prior-Authorizations  
Connecticut Dental Health Partnership  
C/O BeneCare Dental Plans  
P.O. Box 40109  
Philadelphia, PA 19106-0109**



## Adult Dental Questions and Answers

### **Q1. Can a provider office bill for an amalgam filling when providing a composite filling?**

A. No, an office can only bill for the actual service that is delivered.

### **Q2. If a provider's office sends the client to another office to have the amalgam filling done (in amalgam-free offices) what support will they have to get the client back to their office as a regular patient?**

A. While the CTDHP encourages a dental home, the client has the freedom to choose where they get services within the network.

### **Q3. Although the provider understands they can submit a PA, many providers feel that if a client is new to their practice and need the extra time to do a more detailed exam, they will be limited in the time required because they cannot be compensated accordingly with a comprehensive exam.**

A. While the Medicaid Program allows for a certain benefit package the provider is responsible to provide clinically appropriate treatment to the patient. The provider's compensation should not be a determining factor in rendering appropriate care. A comprehensive exam (D0150) will be approved through the PA process as long as the client has not had one within the last year. If there is a **legitimate** reason for an office change, the one year time limit will be waived. If there is not a legitimate reason for the office change the provider is allowed to charge the full fee for this service. The provider should encourage their patient to choose and remain with a Dental Home.

### **Q4. What about adult developmentally disabled patients? They need to be seen every 3 months?**

A. Adult developmental delayed clients are not considered to be healthy adults since many are on multiple medications and have other health conditions. Currently, the additional cleaning is handled through the PA or post procedure process. Documentation must be included on line 35 of the PA form describing the client's condition.

### **Q5. Some providers are stating that in their opinion it is not good oral hygiene to get a cleaning once per year.**

A. The current dental literature is pointing to re-evaluating the frequency of recall visits and dental prophylaxis stating that these services should be customized to each patient. A second cleaning may be submitted for preauthorization **if the client has a medical condition or dental condition that warrants a second cleaning**. The preauthorization claim form must include the reason for the second cleaning. If the second cleaning is not approved the dental office may document the cleaning will not be paid for by the plan and if the client chooses to proceed with the treatment the client is responsible

to pay up to the office's full fee for service rate. The client must sign a document that they agree to pay out of pocket for this cleaning.

**Q6. In cases of pregnant and lactating women, where more frequent cleanings (other than one time per year) are recommended or needed, will that be covered?**

A. Currently, the additional cleaning is handled through the PA or post procedure process. Documentation must be included on line 35 of the PA form describing the client's condition.

**Q7. Providers want to know if they can do free upgrades if they are not charging the client.**

A. Not as a general rule. The practice is strictly limited to the provision of services on the fee schedule. Although DSS regulations permit clients to pay out of pocket for non-covered goods, the federal Medicaid regulations do not permit clients to pay out-of-pocket for a differential or premium for an add on or upgrade to a covered service. Therefore, the Medicaid program does not permit the dentist to charge for the dental service such as a cast removable partial denture and allow the client or a third party on behalf of the client to pay the difference for a Valplast (nylon) partial denture. If an office wants to provide a service at no charge to either the client or the Medicaid Program (pro bono) they may do so.

**Q8. Providers are concerned with PA films being limited to four in a 12 month period. They are questioning what they should do in the case of an emergency and need to take a film?**

A. If a client has had 4 PA x-rays taken in the last rolling 12 months and a provider has to take an x-ray for emergency treatment the provider should take the x-ray and submit it through the preauthorization process for approval. The preauthorization claim form should indicate the reason for the x-ray. A provider's office should always attempt to obtain x-rays taken in other offices and utilize previous x-rays when clinically appropriate.

**Q9. Can an office charge a patient for a higher end denture?**

A. The office may charge a patient for a higher end denture **ONLY if and when** the client chooses to pay for it. The office must charge the client for the higher end denture and cannot bill the Medicaid plan for the service. The patient must be offered the base denture at no out of pocket expense to the client with the option for the other denture with the out of pocket expense. The office must document the services and get informed consent from the responsible party.

Although our regulations permit clients to pay out of pocket for non-covered goods, the Medicaid program does not permit clients to pay out-of-pocket for a differential or premium for an add on or upgrade to a covered service. Therefore, the Medicaid program does not permit the dentist to charge DSS for the base denture and allow the client (or a third party on behalf of the client) to pay the difference for a higher grade denture.

**Q10. What is the correct way to discuss and bill for a procedure where the client requests an upgrade? For example, a client requests a composite resin restoration when an amalgam is the covered benefit?**

A: In instances where a client requests a more costly procedure when a less costly benefit is paid by the Medicaid program, **the client becomes responsible for the entire charge of the upgraded service.** The one exception to this rule concerns the coverage of porcelain fused to metal crowns. At the provider's discretion, a no charge upgrade can be made for the client. The client may be provided with a porcelain fused to metal crown if the provider agrees to charge Medicaid for the cast metal crown. If the client requests a high noble metal or other premium crown, the client may pay for the entire cost of the premium crown. **The client can never be balance billed for a service covered or billed to the CTMAP program.** In summary, the provider cannot bill Medicaid, receive payment and collect the balance due for the premium service from the client or a third party representing the client.

**Q11: Can a provider charge HUSKY clients for missed or broken appointments?**

**No,** Federal Medicaid policy does not allow providers to charge Medicaid clients a fee for broken appointments. In addition, missed appointments are not a distinct, reimbursable Medicaid service, but are considered a part of providers' overall cost of doing business. Please see Bulletin **PB15-05** for complete details.

Providers are also not allowed to collect an up-front deposit that is retained in the event that the client breaks a scheduled appointment.

**Q12: Can a provider dismiss a HUSKY client from their practice for breaking appointments?**

A: If the client does not adhere to the provider's office policy regarding cancelling appointments, they can be dismissed from the practice by the provider. Consult your malpractice insurance company for any specific requirements that may exist for dismissing a non-compliant patient.

**Q13: What date of service should be used when submitting a claim for a denture or crown?**

A: Claims for dentures and crowns should show a date of service which reflects the actual placement date to the client. Please be aware that delivery of dentures requires the completion of the acceptance form attesting that he or she understands the new replacement policy and that his/her denture prosthesis is acceptable.

## Dental Anesthesia Prior Authorization Requirements

Dental anesthesia for Connecticut Dental Health Partnership clients is limited to those clients with behavior management problems, developmental delay and those undergoing multiple, non-simple, extractions. Dental Anesthesia is not a covered benefit for any other dental procedures or in any circumstances other than those described below unless there is a documented **unusual condition** dictating medical necessity.

To request prior authorization, providers who do not limit their practice to the specialty of dental anesthesia or oral and maxillofacial surgery must complete an Anesthesia Prior Authorization Form (sample shown below). The required documentation as described below is in conjunction with Prior Authorization requests for any dental procedures to be performed under anesthesia, must include the radiographs and other documentation necessary for review of the proposed dental procedures. Please note, requests will only be considered for providers who hold a valid anesthesia permit issued by the Department of Public Health. Send completed forms to:

**CT Medicaid Prior Authorizations**  
**C/O Dental Benefit Management, Inc./BeneCare**  
**P.O. Box 40109**  
**Philadelphia, PA 19106-0109**

### Dental Anesthesia Coverage Guidelines and Prior Authorization Requirements

ADA Procedure Code	Description	Benefit Limitations	Coverage Criteria
D9220*	Deep Sedation/ General Anesthesia First 30 minutes	Covered for clients under the age of nine (prior to 9 <sup>th</sup> birthday) or clients that have a demonstrated cognitive impairment/need such as autism, cerebral palsy, hyperactivity disorder or sever/profound developmental delay for behavior management related to the dental procedures being performed.	Covered for clients age 9 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 the removal of impacted third molars. Not a covered benefit for clients age 9 or over for the extraction of a single tooth or general dental services. Not a covered benefit for clients 21 or over for the extraction of less than 5 single teeth excluding third molars or for general dental treatment.
D9221*	Deep Sedation/ Add'l 15 minutes		

D9230*	Analgesia, Anxiolysis, Inhalation NO2 –	Covered for clients under the age of nine (prior to 9th 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 twenty-one (21) or over for dental services.  Not a covered benefit for clients age nine (9) or over for the extraction of a single tooth or general dental services.
D9241*  D9242*	Intravenous Conscious Sedation/ Analgesia First 30 Minutes  Intravenous Conscious Sedation/ Analgesia Each Add'l 15 min	Covered for clients under the age of nine (prior to 9 <sup>th</sup> birthday) or clients that have a demonstrated cognitive impairment/need such as autism, cerebral palsy, hyperactivity disorder or sever/profound developmental delay for behavior management related to the dental procedures being performed.	Covered for clients age 9 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 the removal of impacted third molars. Not a covered benefit for clients age 9 or over for the extraction of a single tooth or general dental services. Not a covered benefit for clients 21 or over for the extraction of less than 5 single teeth excluding third molars or for general dental treatment.

**\*For reasons of medical necessity, exceptions may be made to the above procedures.**

## **Anesthesia Prior Authorization Documentation Requirements**

Anesthesia prior authorization requests must include the following documentation:

- Completed Anesthesia Prior Authorization Request Form;
- Descriptive Narrative or the condition(s) requiring general anesthesia or conscious sedation;
- Medical necessity certification form from an independent physician or the Department of Developmental Services detailing the specific medical diagnosis and requesting dental anesthesia;
- Anesthesia flow sheet containing the pharmacologic agent, dose and duration of administration, and
- Vital signs must be maintained in the patient's record.

## **Dental Anesthesia Prior Authorization Form**

(shown on next page)



the dental plan for HUSKY Health

Anesthesia Prior Authorization Request Form [Must be completed by the performing provider and submitted with Prior Authorization documentation for dental procedures for which anesthesia is requested]

Date of Request: \_\_\_\_\_ Routine \_\_\_ Urgent \_\_\_ Expedited \_\_\_

Section I: Client Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Client Identification Number \_\_\_\_\_
Date of Birth \_\_\_\_\_ Client's PCP \_\_\_\_\_ PCP's Phone Number \_\_\_\_\_

Section II: Clinical Documentation

Dental Diagnosis: \_\_\_\_\_

Medical Conditions Warranting Medical Necessity for Dental Anesthesia: \_\_\_\_\_

Proposed Dental Procedures/Services: \_\_\_\_\_

Proposed Anesthesia: Include Pharmacological Agents to Be Used and Anticipated Units of Anesthesia Needed \_\_\_\_\_

Section III: Provider Information

Requesting Provider Name (Print) \_\_\_\_\_ NPI (Print) \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

CTDHP Review: Approved \_\_\_ Denied \_\_\_ Modified \_\_\_

Units Approved: \_\_\_\_\_ Prior Authorization Approval Number: \_\_\_\_\_

Prior approval is not a guarantee of payment of claims. Payment of claims is subject to member eligibility, frequency limitations, and coverage guidelines.

Connecticut Dental Health Partnership
195 Scott Swamp Road, Suite 101
Farmington, CT 06032

Phone: (203) 507-2300
Fax: (203) 674-8157
Client Services: (866) 420-2924
Provider Services (888) 445-6665

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## **Claim Submission and Payment Requirements**

Claims from enrolled providers are processed by HP Enterprises and may be submitted on a **RED J434 ADA Claim Form** claim form, through the HP Enterprises secure web portal or they may be sent electronically using your own software.

Electronic submitters should refer to the HP Enterprises Companion Guide which is located on the Trading Partner tab of the state website, [www.ctdssmap.com](http://www.ctdssmap.com). Dental providers may also use the web portal claim submission feature available on the state website, or HP's Provider Electronic Solutions software to submit dental claims. For additional information on electronic claim submission, please contact HP Enterprises at 800-842-8440.

Red J434 ADA claim forms can be obtained by calling the American Dental Association at 800-947-4746, Monday – Friday between the hours of 8:00 AM and 5:00 PM Central Standard Time. You can choose to order the forms on-line from the ADA website at [www.adacatalog.org](http://www.adacatalog.org). The ADA form may also be obtained from other form vendors.

Providers have one year from the date of service to submit claims for payment. Completed paper claims should be mailed to:

HP Enterprises  
PO Box 2971  
Hartford, CT 06104

## **Remittance Advice**

All claims received by HP Enterprises are reported to providers on a bi-monthly Remittance Advice (RA). RAs are sent electronically via the secure Provider Web portal and are available in either ASCX12N835 Payment/Advice format or in a PDF format which provides the paper RA version. Providers will have access to the last 10 RAs on the secure web site. Providers are encouraged to save copies of their RAs to their own computer systems for future access as only the 10 most recent RAs will be available through the HP Enterprises provider web site.



