A MANUAL FOR HUSKY HEALTH AND COVERED CT DENTAL PROVIDERS

CONNECTICUT DENTAL HEALTH PARTNERSHIP
the dental plan for HUSKY Health

DENTAL PROVIDER MANUAL

The Connecticut Dental Health Partnership is the Dental Plan for HUSKY Health and Covered CT and is administered by BeneCare Dental Plans under a contract with the Connecticut Departmetn of Social Services (DSS).

Introduction

The Connecticut Dental Health Partnership is the Dental Plan for HUSKY Health and is administered by BeneCare Dental Plans under a contract with the Connecticut Department of Social Services (DSS).

DSS is the single state agency responsible for the administration of the State's Connecticut Medicaid Assistance Program and the Children's Health Insurance Program (SCHIP). Medicaid and SCHIP are collectively described as the HUSKY Health Program.

The Connecticut Dental Health Partnership (CTDHP) operates a responsive Member Services Call Center for over 1,000,000 Connecticut residents who benefit from dental and oral healthcare as a part of HUSKY Health (Medicaid) programs. There are also a team of statewide Community Engagement Specialists and Oral Health Navigators to provide training and help members with more complex oral healthcare needs.

The Partnership oversees a broad network of dental providers who provide quality services to HUSKY Health and Covered CT members.

The Connecticut Dental Health Partnership also handles the Grievance and Appeals process. Grievance and Appeals Representatives are here to help you understand why a service may or may not be covered and guide you through all the steps in the appeals process.

The Connecticut Dental Health Partnership is committed to achieving Oral Health Equity. Our mission is to enable all HUSKY Health members to achieve and maintain good oral health. We work to ensure all members have equitable access to oral health services.

Welcome to the Connecticut Dental Health Partnership

Dear HUSKY Health and Covered CT Participating Dental Provider:

Welcome to "The Partnership!" Programs covered under The Connecticut Dental Health Partnership (CTDHP) include: The State of Connecticut's publicly funded dental care programs, HUSKY A, HUSKY B, HUSKY C (Traditional Medicaid Title XIX Fee for Service), HUSKY D (Medicaid for Low Income Adults) and the Covered CT dental program launched in 2022. CTDHP's mission is to enable all HUSKY Health members to achieve and maintain good oral health. We work to ensure all members have equitable access to oral health services.

These programs which address the oral health needs for approximately 1,000,000 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. DSS is the lead Medicaid 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 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 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 section which contains information on marketing guidelines as well as appointment scheduling guidelines and other important information. CTDHP will be sharing a variety of programmatic updates and notices with you in the future, so please be on the look-out for these communications and place them with your manual.

Thank you for your continued participation in our HUSKY Health and Covered CT programs.

Sincerely,
Connecticut Dental Health Partnership

Contents

Chapter 1
Contact Information and Member Eligibility

Provider Services Call Center

Our Member Services Call Center is here to provide you and your patients with assistance in securing dental services. The Call Center is staffed Monday – Friday from 8:00 AM to 5:00 PM. Providers may call the following numbers for assistance:

Contact	Phone Number
CTDHP Member Services and Local Provider Services	**855-CT-DENTAL (855-283-3682) 866–420–2924**
Facsimiles	**860–674–8174**
Prior Authorization Requests and Inquiries	**888–445–6665**
Gainwell Provider Assistance Center	**800–842–8440**

Mailing Addresses

Prior Authorization and Post Procedure Authorizations Requests for Non–Orthodontic Services:

CT Medicaid Prior Authorizations
C/O Dental Benefit Management/BeneCare
555 City Avenue
Bala Cynwyd, PA 19004

Prior Authorization for Orthodontic Treatment Requests:

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

HUSKY Health Dental Plan - CTDHP Website – www.ctdhp.org

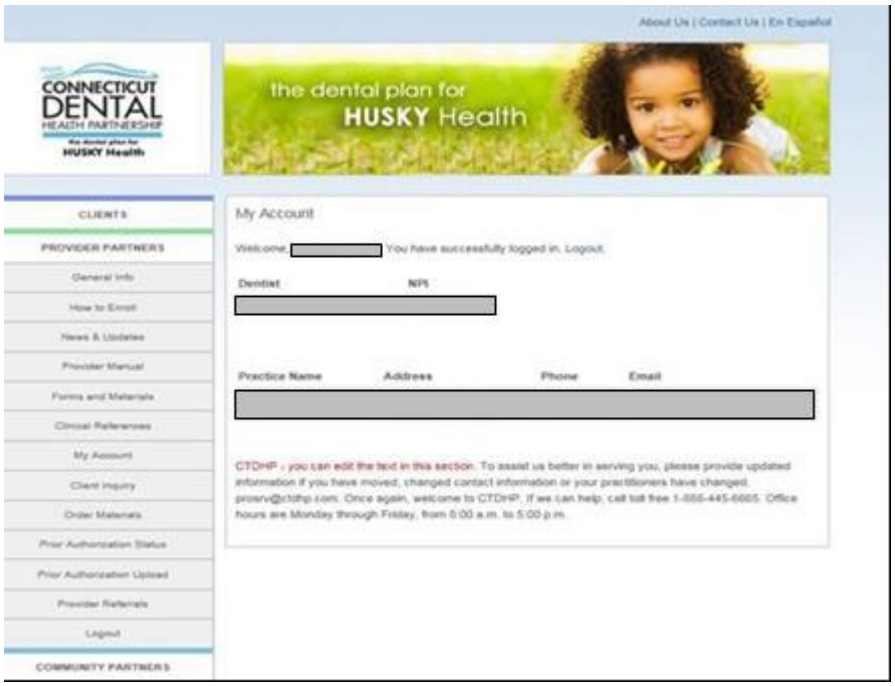
Providers may access the CTDHP website at www.ctdhp.org. Simply click on Dental Providers at the top. The Providers section of the website has both public information and a secure portal. This area of the site provides general information resources including forms, educational brochures and more.

The Providers' **secure portal** is used to access Protected Health Information regarding Prior Authorization status and Client History by date of service. Providers will need to use their National Provider Identifier (NPI) and Federal Tax Identification Number (TIN) to access the secure area of the website.

Click on the link labeled "**Provider Login**." To sign into the secure portal, you will need your Billing NPI number as well as your Federal Tax ID number. Enter the information in the boxes provided.

Once you have successfully entered your identifying information, you will see this screen populated with your personal information:

You may now use the links on this page and on the left of this page to check client eligibility, treatment history and find additional participating providers or upload information to BeneCare.



Client Eligibility and Treatment History

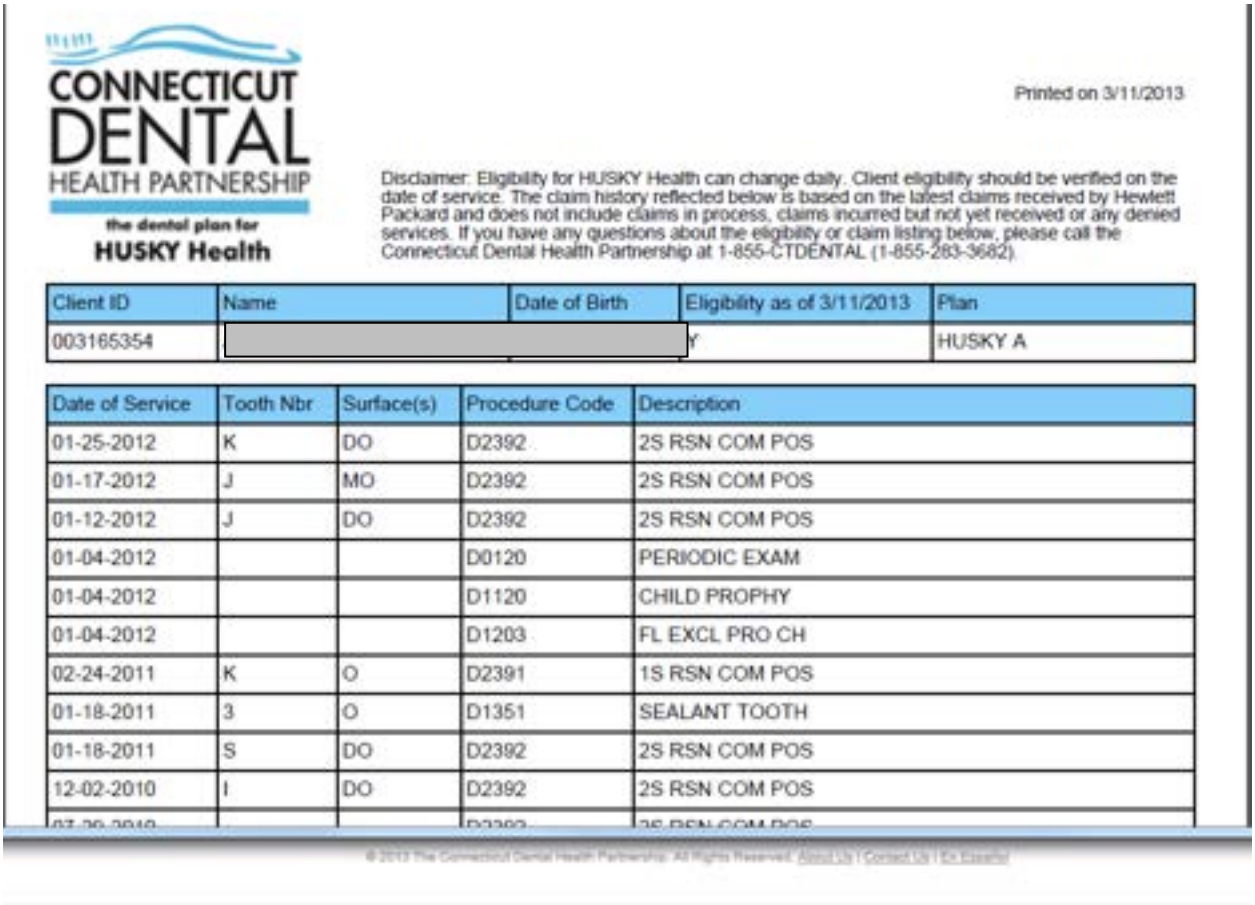
To check Client Eligibility and Treatment History follow the steps outlined below:

Click on the link labeled **Client Inquiry**. You will then see the following screen:

For each client that you wish to check eligibility for, please enter the client's Medicaid ID number, Date of Birth, and click on the "Add Client" button.

As you add clients to the eligibility report, they will appear on the screen in list format. When you have finished adding clients to the report, you can either click on the "**Remove" button to delete a client** from the report, or click on the hyperlink in the yellow box labeled "**Click Here" to run the report.**

The screen will return the current day's eligibility status as well as a listing of historical dental procedures on file. **In the case of an adult client, the report will also show the amount of dental benefit that has been used towards the annual $1,000 maximum benefit. See example below:**



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Printed on 3/11/2013

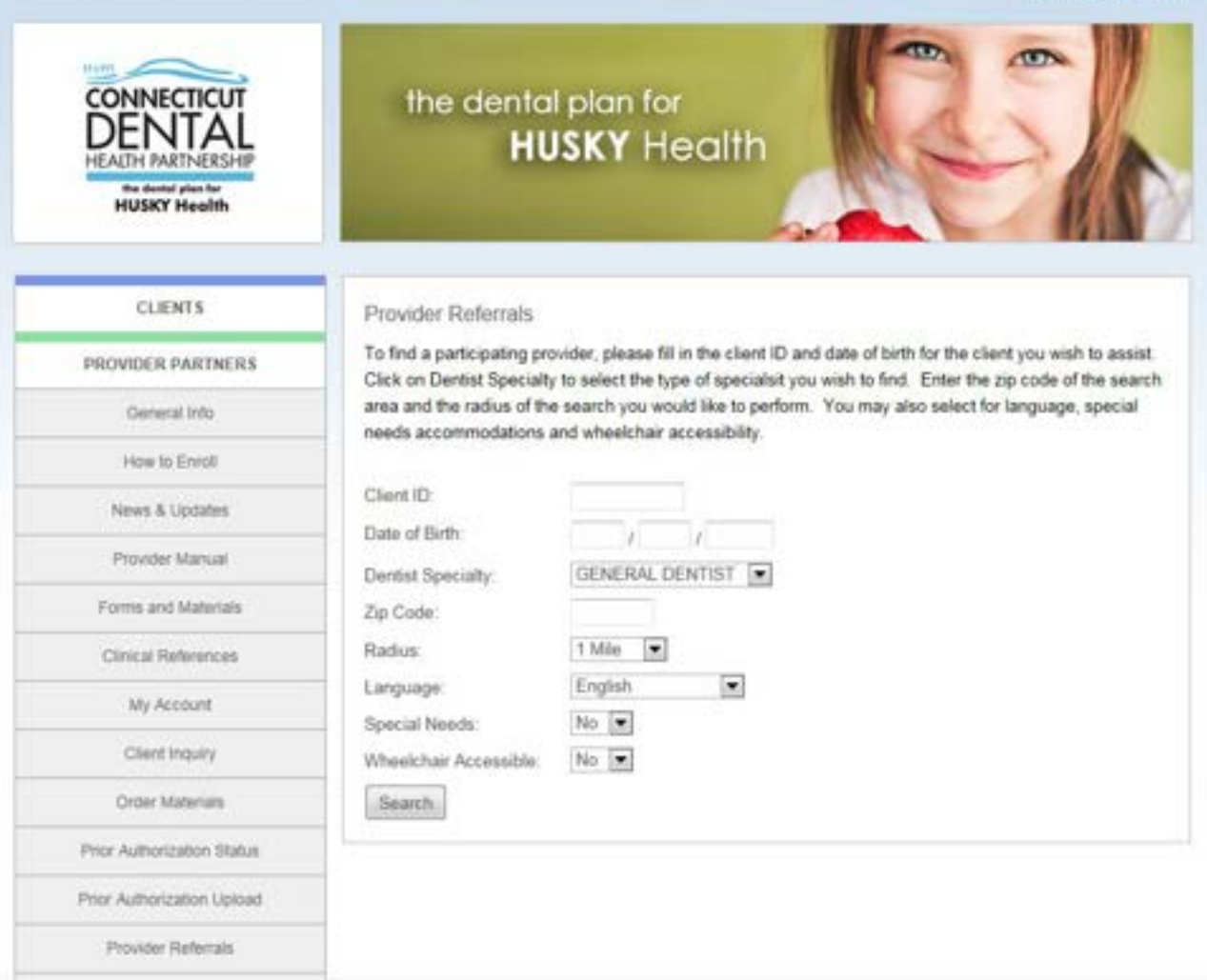
Disclaimer: Eligibility for HUSKY Health can change daily. Client eligibility should be verified on the date of service. The claim history reflected below is based on the latest claims received by Hewlett Packard and does not include claims in process, claims incurred but not yet received or any denied services. If you have any questions about the eligibility or claim listing below, please call the Connecticut Dental Health Partnership at 1-855-CTDENTAL (1-855-283-3682).

Client ID	Name	Date of Birth	Eligibility as of 3/11/2013	Plan
003165354	[redacted]		Y	HUSKY A

Date of Service	Tooth Nbr	Surface(s)	Procedure Code	Description
01-25-2012	K	DO	D2392	2S RSN COM POS
01-17-2012	J	MO	D2392	2S RSN COM POS
01-12-2012	J	DO	D2392	2S RSN COM POS
01-04-2012			D0120	PERIODIC EXAM
01-04-2012			D1120	CHILD PROPHY
01-04-2012			D1203	FL EXCL PRO CH
02-24-2011	K	O	D2391	1S RSN COM POS
01-18-2011	3	O	D1351	SEALANT TOOTH
01-18-2011	S	DO	D2392	2S RSN COM POS
12-02-2010	I	DO	D2392	2S RSN COM POS

Provider Referrals

Providers will also have access to a locator tool which can be used to find a general dentist or specialist in a provider or client's area. To access the tool, click on **Provider Referrals** on the left side of the page. The following screen will appear:



Fill in the:

- Client ID
- Client Date of Birth
- Zip Code and preferences for specialty, distance, language and special needs and then click **Search**.

If a search returns no results, it may be necessary to increase the radius and/or refine the selection criteria for language or special needs.

Department of Social Services Website – CT Medical Assistance Program (CMAP)

DSS contracts with Gainwell to maintain the website for the CT Medical Assistance Program (CMAP). It can be accessed at: www.ctdssmap.com.

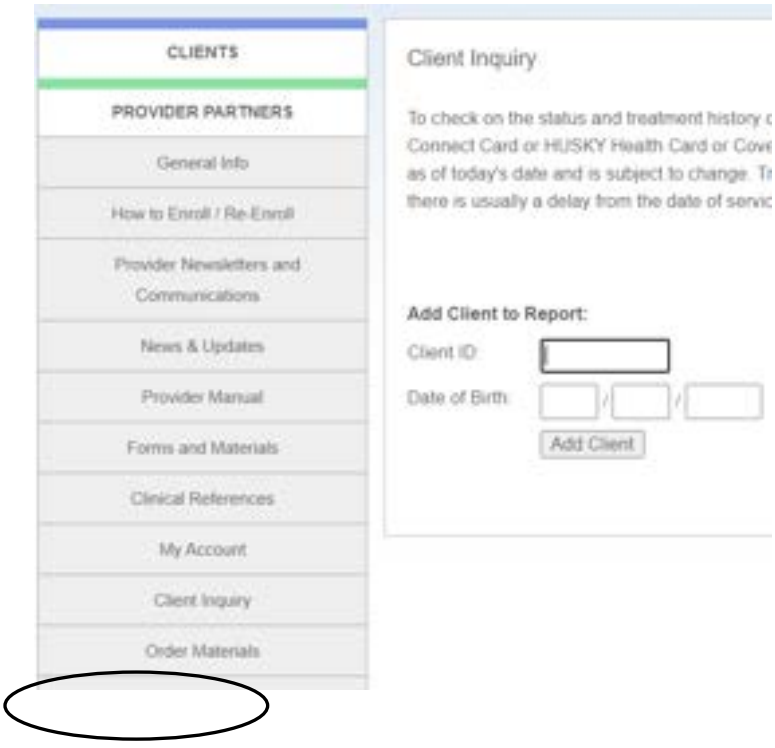
The site provides important information to health care providers about the Connecticut Medical Assistance Program. This site contains a wealth of resources for providers including enrollment, billing manuals, bulletins, program regulations, plus information on Electronic Data Interchange and the Automated Eligibility Verification System.

The site has both public-facing and a secure portal. The public-facing part of the site important information, provider and trading partner links, pharmacy information, provider publications, provider enrollment and re- enrollment applications and more. The public website does not require the user to have a password.

This secure area of the website requires you to log in. The secure site gives provider specific information concerning claim processing, client eligibility verification, secure file uploads & downloads and other similar functions. You can also review your remittance advices and much more. For assistance or questions concerning how to log into the secure section of the web portal, please contact Gainwell Provider Relations at **800-842-8440**.

Client Eligibility

Please note, it is important to verify client eligibility each time you see a HUSKY Health or Covered CT member. Just like commercial insurance, members may lose their eligibility for a number of reasons. It is important to retain the record number when you obtain the member's eligibility status, as in very rare instances, the eligibility record may be inaccurate. This number will allow you to prove that you verified the member eligibility on the date of service and will allow you to be reimbursed for any covered services you performed.



You can check member eligibility after logging on to the secure portal on the CT Dental Health Partnership website: https://ctdhp.org/dental-providers/provider-login/. Once you log in, click **Client Inquiry** to determine eligibility.
You can also check member eligibility status on CMAP.

- www.ctdssmap.com
- Choose "**Information**"
- Scroll down and select "**Publications**"
- Scroll down to Chapter 4, "**Client Eligibility**"
- Click "**Chapter 4**"

Lastly, you can check with the **Automated Voice Response System (AVRS)**. The Automated Voice Response System (AVRS) is available 24 hours a day, seven days a week (except for maintenance) and allows self-service features for enrolled providers such as client eligibility verification, and access to client/program information through a touch tone telephone.

1. The provider initiates the request by dialing **1-800-842-8440 (toll free)**.

2. The system interacts in a series of verbal prompts and responses as the provider, client, and specific service date data are entered. The system responds to the provider requests in the form of a voice response.

Chapter 2
Contracting – Program Enrollment and Re-enrollment

Program Enrollment / Re-enrollment Process

Online Enrollment Tool

Providers are required to submit enrollment/re-enrollment applications via the web using the Online Enrollment Tool at www.ctdssmap.com.

In order to enroll or re-enroll online, you must first have all of your material assembled for the enrollment process. You will need:

- Your Federal and State Tax ID
- Your NPI (National Provider Identifier Standard)

And a copy of your:

- Liability insurance
- Specialty certificate
- Diploma
- Office owners will need a W-9 and EFT (Electronic Funds Transfer) information.

Note: Once you begin with the enrollment wizard, you cannot save the application and return to the enrollment application at a later time.

- Go to the www.ctdssmap.com website;
- Go to the "**Provider**" box and scroll down to "**Provider Enrollment**";
- Click "**Next**" to start the enrollment wizard. It will walk you through the information needed;

Remember: Once you begin the enrollment process, you cannot save the information and return to it at a later date.

NOTE: Re-enrollments must complete the credentialing process prior to your expiration date. Please submit your re-enrollment information 6 – 8 weeks prior to your expiration date to ensure uninterrupted enrollment in the program. Also, re-enrollment applications cannot be back-dated.

Dental Taxonomy Assignment Chart

The CT Dental Health Partnership offers personalized assistance with the Enrollment and Contracting processes.

By contacting CTDHP at **860-507-2307**, we will work with you and your office staff to get your office enrolled or re-enrolled with the CMAP network. Once enrolled in the program, you will need to submit new contracts in the event that you change Tax IDs, add individuals to a group

practice, add new office locations open to HUSKY Health or Covered CT members or add new provider specialties to a practice.

The Department of Social Services recognizes and enrolls providers in the following dental specialties:

Specialty	**Taxonomy**
Dental Anesthesiologist	1223D0004X
General Practice Dentist	1223G0001X
Hygienist	124Q00000X
Endodontist	1223E0200X
Oral and Maxillofacial Pathologist	1223P0106X
Oral and Maxillofacial Radiologist	1223D0008X
Oral and Maxillofacial Surgeon	1223S0112X
Orthodontist	1223X0400X
Pediatric Dentist (Pedodontist)	1223P0221X
Periodontist	1223P0300X
Public Health Dentist	1223D0001X
Prosthodontist	1223P0700X
Dental Resident in Training Program	390200000X

Paper Enrollment Process

Dental providers are required to enroll via the secure web portal you can access at: https://ctdhp.org/dental- providers/provider-login/. If you are unable to submit your application via the web portal you may submit a paper application to Gainwell with a letter that requests an exception to the requirement with details of the reason for the request.

A PDF of the enrollment form can be downloaded by following the steps below:

- Go to the website www.ctdssmap.com;
- Click on "**Information**" and a drop-down box will give the option "**Publications**"
- Choose this option, and then scroll down the page to the "**Forms**" section;
- Continue to scroll down the list to "**Provider Enrollment/Maintenance Forms**" and click on **Provider Enrollment Application**."
- The enrollment package will download as an Adobe Acrobat (.pdf) file.

For the most up to date enrollment requirements, please consult the ctdssmap.com website.

Chapter 3
Fee Schedule

The published fee schedule lists the CTDHP payable procedure codes and the associated fees for pediatric Members (under age 21) and adult Members (21 years old and older).

Dental Hygienist Fees and Covered Procedures

Dental hygienists receive 90% of the payment rate of the fees listed on the fee schedule as applicable to the age of the Member. Claim submission and payment for hygienist services are limited to the following procedures:

Procedure	Code
Periapical X-Rays	D0220, D0230
Bite Wings	D0270, D0272, D0274
Caries Risk Assessment	D0601, D0602, D0603
Unspecified Diagnostic	D0999
Prophylaxis Adult/Child	D1110, D1120
Topical Fluoride Application	D1208
Tobacco Counseling	D1320
Sealants	D1351
House/Extended Care Call	D9410

The CDT Code and Nomenclature above have been obtained from Current Dental Terminology (including procedure codes; nomenclatures; descriptors and other data contained therein).

How to Use the Fee Schedule

The fee schedule is broken out to show the prior authorization requirements by dental specialty. To use the fee schedule, locate the procedure code desired and follow the line across to your applicable dental specialty to see if prior authorization is required. The fee schedule will also note the procedures that require post procedure review.

Procedures which require prior authorization/post procedure review are identified on the fee schedule using the following codes:

PA Prior Authorization is required prior to providing service for all ages

PR Post Procedure Review required after the service has been performed and prior to payment being made

PAR Prior Authorization required for Members over 21 years old and Post review required for under 21 years old

<21 Prior authorization is required for this service when provided for a Member under the age of 21

>21 Prior authorization is required for this service when provided for a Member over the age of 21

21-69 Prior authorization is required for Members 21 years of age and older, but less than 70 years old

An empty box on the fee schedule signifies that no prior authorization is required.

How to Download a Copy of the Fee Schedule

From time to time, updates may be made to the fee schedule. To view and/or print the most recent version of the fee schedule, go to www.ctdssmap.com. Click on the Provider tab on the main menu. Scroll down to "Fee Schedule Download" and click on the link. Choose "Accept" in order to view the fee schedules.

This will bring you to a new page which lists all the available fee schedules. Scroll down to "Dental." This will display the current dental fee schedule for both adults and children in an Excel-like format.

These updates may also be available on ctdhp.org. Fee Schedule – HUSKY Dental (ctdhp.org)

HUSKY B Fees and Co-Pays

As of July 1, 2010, Husky B members are responsible for co-pays on many dental procedures. The fee schedule shows the percentage of the fee that the member is responsible to pay as an out of pocket expense. For example, if the fee shown for a procedure is $100.00 and the HUSKY B co-pay amount is shown as 20%, the member would be responsible for $20.00. Please note: If a provider bills less than the allowed amount as shown on the fee schedule, the member would only be responsible for the percentage shown on the fee schedule and applied to the billed amount. When the provider fee is higher than what the Medicaid fee schedules shows, the provider must bill the co-pay percentage against the Medicaid listed fee schedule amount.

View the Dental Fee Schedule online:
https://ctdhp.org/dental-fee-schedule/pdf

Chapter 4
Department of Social Services
Medical Services Policy Overview

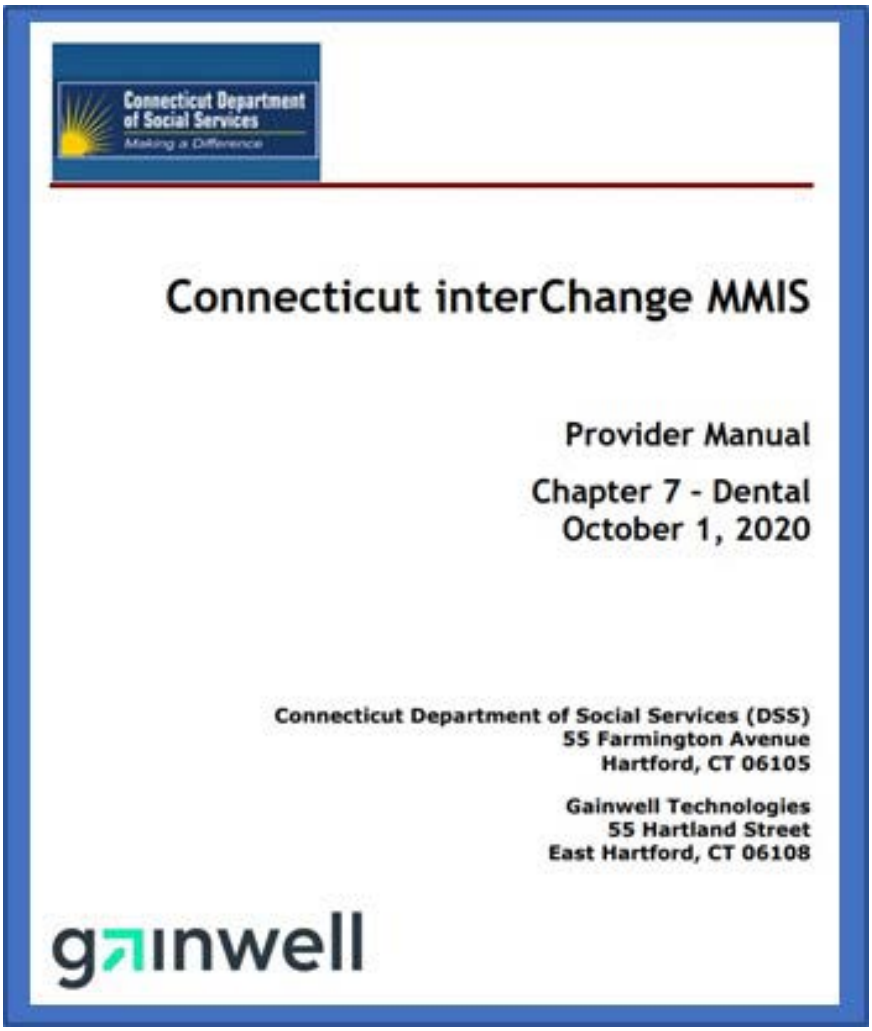
Chapter 4 outlines current regulations, and how to access the most current policy. It also reviews the policy sections, The Medical Necessity: Section 22 of Public Act 10-03 (Deficit Mitigation Act) and Commonly Asked Questions – regarding missed appointments and financial arrangements.

Current Regulations

Chapter Seven 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 as related to the client's medical necessity.

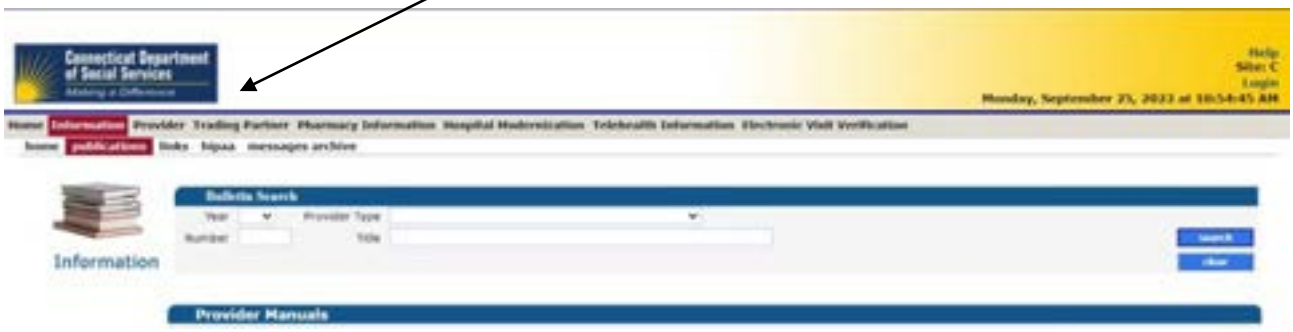
CTDHP/BeneCare dental consultants may request additional prior authorization documentation to better evaluate whether a service is appropriate or not.

Any updates to state policy will be communicated to providers in the form of a Policy Transmittal or bulletin distributed by Gainwell. You should maintain copies of them as they are received.

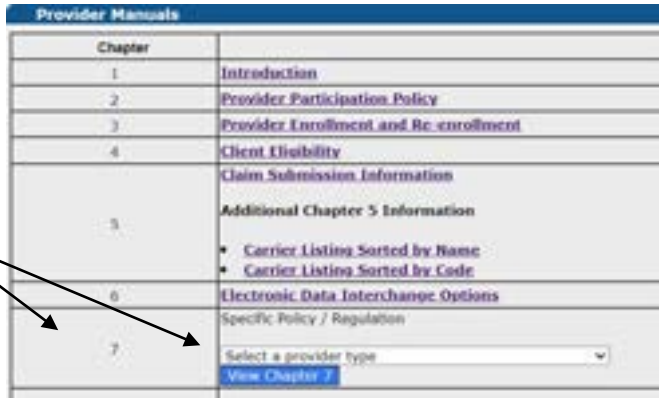


How to Access the Most Current Policy

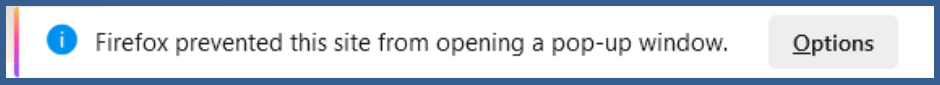
1. To access Chapter Seven, go to www.ctdssmap.com
2. On the left-hand menu bar, locate the "**Information**" box
3. Select "**Publications**" from this box



4. Locate Chapter 7
5. Select "**Dental**" from the drop-down box that states "**Select a Provider Type**"
6. Click "**View Chapter 7**"



IMPORTANT TIP: If you have trouble accessing Chapter 7 at CTDSSMap.com – be sure you check your Pop Up Blockers and check to allow access to the CTDSSMap site PDFs. (look at the top of your screen for a message like this:



and ALLOW the pop ups. Could be on the right or left top of your screen depending on your browser.

New regulations are expected to be released in the future. You will be given a thirty (30) day notice by the Department before any new regulations become effective.

Department of Social Services Medical Services Policy

This section outlines the medical services policy and regulations of the Connecticut State Agencies as they relate to dental services, dental practices, dental hygienists and clinics. Topics in each section below include:

- Scope
- Definitions
- Provider participation
- Eligibility
- Services covered and limitations
- Services not covered
- Billing procedures
- Documentation of services provided
- Summary of Benefits Grid

Dental Services

Chapter 7 Pgs 1-19

For the purposes of this section, dental services are diagnostic, preventive, or restorative procedures, performed by a licensed dentist in a private or group practice or in a clinic; a dental hygienist, trained dental assistant or, or other dental professionals employed by the dentist, group practice or clinic, providing such services are performed within the scope of their profession in accordance with State law.

These services relate to:

I. The teeth and other structures of the oral cavity; and
II. Disease, injury, or impairment of general health only as it relates to the oral health of the recipient

Clinics

Chapter 7 Pgs 20-23

For the purposes of this Section, clinics are facilities not associated with a hospital. They provide medical or medically-related services for diagnosis, treatment and care of persons with chronic or acute conditions.

Dental Clinics

Chapter 7 Pgs 24-36

A dental clinic provides diagnostic, preventive, or restorative procedures to outpatients in a clinic staffed by dentists, dental hygienists, dental assistants and other dental professionals performing within the scope of their profession in accordance with State law. Services performed relate to

I. The teeth and other structures of the oral cavity; and

II. Disease, Injury, or impairment of general health only as it relates to the oral health of the recipient.

Requirements for Payment of Public Health Dental Hygienist Services (Regulations of Connecticut State Agencies)

Chapter 7 Last 7 pages

Sections 17b-262-693 to 17b-262-700, inclusive, set forth the requirements for payment of public health dental hygienist services for persons determined eligible for Connecticut's Medicaid Program pursuant to Section 17b-262 of the Connecticut General Statutes.

Summary of Benefits Grid

The summary of dental benefits grid for providers is located in the dropdown menu for Dental Providers on ctdhp.org. It is also easily accessible from the Welcome page:

https://ctdhp.org/dental-providers/welcome/

Dental-Coverage-Limitations-By-Program-provider.pdf (ctdhp.org)

Medical Necessity: Section 22 of Public Act 10-03 (Deficit Mitigation Act)

(a) For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

(b) Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.

(c) Upon denial of a request for authorization of services based on medical necessity, the individual shall be notified that, upon request, the Department of Social Services shall provide a copy of the specific guideline or criteria, or portion thereof, other than the medical necessity definition provided in subsection (a) of this section, that was considered by the department or an entity acting on behalf of the department in making the determination of medical necessity.

(d) The Department of Social Services shall amend or repeal any definitions in the regulations of Connecticut state agencies that are inconsistent with the definition of medical necessity provided in subsection (a) of this section, including the definitions of medical appropriateness and medically appropriate, that are used in administering the department's medical assistance program. The commissioner shall implement policies and procedures to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after implementation. Such policies and procedures shall be valid until the time the final regulations are adopted.

Commonly Asked Questions

Services Which Cannot be Charged to an Eligible HUSKY Member

Can a provider charge HUSKY member for missed appointments?

No. Federal Medicaid policy **does not allow** providers to charge Medicaid members a fee for missed appointments. In addition, missed appointments are not a distinct, reimbursable Medicaid service, but are considered a part of providers' overall cost of doing business.

Providers are also **not allowed to collect an up-front deposit** that is retained in the event that the HUSKY member breaks a scheduled appointment. Please see bulletin **PB15-05** for complete information on this topic.

Can a provider have a private Financial Arrangement with a Medicaid covered member?

No. A provider may not make arrangements with a Medicaid covered patient to pay for Medicaid covered services outside the program. If a provider sees a Medicaid member they must agree to payments as dictated by current Medicaid policy. Personal agreements between dentist and patient cannot be made in conflict of Medicaid policy.

This policy includes providers who have restricted their patient base in any way.

Can a provider give a HUSKY Health member a service that is not covered, charge HUSKY Health (Medicaid) and then balance bill the patient?

No. Dental providers cannot provide a service that is not covered (upgrade or alternate treatment), charge Medicaid and then charge the patient the difference.

Chapter 5
Connecticut Dental Health Partnership Policy Standards of Care

Our Mission

The Connecticut Dental Health Partnership is committed to achieving Oral Health Equity. Our mission is to enable all HUSKY Health members to achieve and maintain good oral health. We work to ensure all members have equitable access to oral health services.

Dental Home

"The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than 12 months of age and includes referral to dental specialists when appropriate. " by the American Association of Pediatric Dentistry (AAPD) and the American Dental Association (ADA); both of which provide further information regarding services that constitute a dental home. The key features of a dental home are as follows:

- Provides comprehensive care (restoration of cavities, root canal therapy and extractions) including prevention and emergency services
- Care should be accessible, have a fixed location for follow up services, close to the client's home and have regular appointment hours available by week
- It should have a plan for providing emergency care available 24/7, other than providing a referral to the local emergency room
- It should have the capacity to make referrals to specialists if needed (and within the client's network)
- Completes a disease risk assessment for each patient and uses it to design an individualized treatment plan
- Improves or maintains the patient's oral health to a functional level

Appointment Scheduling

CTDHP has established the following scheduling standards:

- **Emergency cases** shall be seen within 24 hours, referred to another dentist or dental specialist or if necessary, referred to an emergency facility for immediate treatment;

- **Urgent cases** should be seen within 48 hours of contact and is not dependent upon convenience for the patient

- **Preventative and non-urgent or emergent care visits** shall be scheduled within eight weeks of contact

- **Specialists** will provide treatment within the scope of their practice and within professionally accepted standards of care and promptness standards for providing such treatment

- **Waiting times** at primary care offices shall be kept to a minimum

- Per federal regulations, Medicaid clients cannot be charged for **missed or cancelled appointments**

In order to ensure the best possible client service, CTDHP asks that all provider offices make use of an answering machine and/or answering service during any hours that the office staff is unavailable to take calls. There must be a method available to patients to contact the provider in the event an emergency occurs; it is not sufficient to refer the client to the local emergency room.

Opening and Closing Panels

Provider offices may contact the CTDHP at any time to open or close panels to new client referrals or limit participation based on program, location or age. CTDHP encourages all general dental offices to consider accepting families, including the parents of children who are clients of the office, which promotes the model of a "dental home." This approach encourages regular visits which improves the oral health of the family. **To change your panel status, please contact the Network Development Assistant at 860-507-2307 for assistance.**

Patient Record Sharing

According to Connecticut General Statutes, Section 20-7d, a copy of the patient's record, including but not limited to, x-rays and copies of laboratory reports, prescriptions and other technical information used in assessing the patient's condition shall be furnished to another provider upon the written request of the patient. The information provided should be readable and in the case of radiographs, of diagnostic quality. The written request shall specify the name of the provider to whom the record is to be furnished. A reasonable fee charged to the client is allowed. We ask that the fee be waived for our clients.

Charging for Goods or Services Provided to Clients

A provider shall not charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for any portion of the cost of goods or services which are covered and payable under the Connecticut Medical Assistance Program. If a client or representative has paid for goods or services and the client subsequently becomes eligible for the medical assistance program, payment made by or on behalf of the client shall be refunded by the provider. The provider may then bill the medical assistance program for the goods or services provided. The provider shall obtain appropriate documentation that the payment was refunded prior to the submission of the claim and shall retain said documentation.

Providers may not charge for medical goods or services for which a client would be entitled to have payment made, but for the provider's failure to comply with the requirements for payment established by state regulations.

Providers shall only charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for goods or services which are not coverable under the Medical Assistance Program, when the client knowingly elects to receive the goods or services and enters into an agreement in writing for such goods or services prior to receiving them.

Annual Provider Surveys

Each year, CTDHP will contact providers to ensure that the information on file for each office remains accurate. The annual survey will be available online for providers to complete. Offices which do not use the online tool will be contacted by CTDHP to complete the survey via fax or mail. The survey takes approximately five minutes to complete. Your cooperation with completing the survey is greatly appreciated and will ensure that the referrals that are sent to you are appropriate to your current practice policies on age, geographic restrictions and special needs. **A sample of the survey form is shown below.**

Providers are encouraged to contact CTDHP with any updates to address, phone numbers, and languages spoken or special accommodations at any time of the year.

Sample Survey

Provider Survey

Please fill out the information in the form below, then click the "Submit" button. A red star next to a survey question indicates a required field.

Your First Name: *

Your Last Name: *

Name of Provider or Practice: *

Billing NPI Number: *

Federal Tax ID: *

Type of Practice: Group *

Physical/Office Address 1: *

Address 2:

City: *

State: Connecticut *

Zip Code: *

Office Phone: *

Office Fax:

Specialty Types:

- ☐ General Practice
- ☐ Orthodontic
- ☐ Oral Surgery
- ☐ Endodontic
- ☐ Pediatric
- ☐ Clinic
- ☐ FQHC
- ☐ Periodontic
- ☐ Other

Plans Accepted:

- ☐ HUSKY A
- ☐ HUSKY B
- ☐ HUSKY C
- ☐ HUSKY D

Minimum Age Seen: *

Maximum Age Seen: *

Bus Route Number: * (If Bus Route # is unavailable, put Y or N)

Languages Spoken in Office: (Language 1)

(Language 2)

(Language 3)

(Language 4)

(Language 5)

Does your practice use an answering service to accommodate after hour needs? *

○ Yes ○ No

Does your practice have an appointment reminder system? *

○ Yes ○ No

If yes, is the appointment reminder system automated? *

○ Yes ○ No ○ N/A

Does your office utilize the CTDHP Oral Health Navigation referral tool resource for patients with complex or acute care needs that would benefit from oral health navigation support? *

○ Yes ○ No

Office Hours:

DAY	FROM			TO		
Monday:	8	00	AM	4	30	PM
Tuesday:	8	00	AM	4	30	PM
Wednesday:	8	00	AM	4	30	PM
Thursday:	8	00	AM	4	30	PM
Friday:	8	00	AM	4	30	PM
Saturday:	8	00	AM	4	30	PM
Sunday:	8	00	AM	4	30	PM

The following is a list of associates that we have on file for your practice:

Please review this list, and make any changes below.

The following is a list of office location(s) that we have on file for your practice:

- [Sample] Location A
- [Sample] Location B
- [Sample] Location C

Please review this list, and make any changes below:

Questionnaire:

1. Are you still participating in the CT Medical Assistance Program?
2. Are you accepting new patients at this time? If you are not accepting new patients now, when would you like to start receiving referrals?
3. Is your office wheelchair accessible?
4. Will your practice accommodate or have a consultation for members with **special health care needs** (i.e. when the member's behavioral, cognitive, medical, or physical needs require either specialized knowledge, increased awareness and attention, adaptation, and/or accommodative measures beyond what is considered routine)?
5. Do any of your providers have specialized training in working with patients with Special Health Care Needs?
6. Does your office have enough space in halls, doorways, and operatory to allow patients with mobility limitations (this includes patients with mobility assistive devices and plus-size or obese patients) to move safely?
7. Is your office able to provide assistance transferring patients in and out of the dental chair?
8. Does your office access language interpretation services for patients?
9. Does your office access interpretation services for patients who are deaf or hard of hearing?
10. Does your office staff receive routine and ongoing cultural competency training?
11. Will your office treat pregnant patients?
12. Will your office treat patients with high-risk pregnancy?
13. Do you require an OB/GYN letter in order to treat the pregnant patient?
14. Will your office communicate with the treating OB/GYN or Midwife?
15. Does your office have any restrictions on treating a pregnant patient? If Yes, please specify the restriction(s) under "Additional Info". Examples of restrictions include any of the following: Restrictions on trimesters, restrictions on preventative, restorative, urgent or emergency care, x-rays, or local anesthesia.
16. Does your practice provide Nitrous Oxide in the office?
17. Does your practice provide IV Sedation in the office?
18. Does your practice provide Oral Conscious Sedation in the office?
19. Does your office perform Cone Beam CT scans?
20. Will your office treat patients at hospital facilities under general anesthesia? If so, what hospital is the dentist affiliated with?
21. Additional information (open ended)

SUBMIT

On Site Visits and Assessments

From time to time offices will be visited by a representative of CTDHP as we partner with you to ensure that your office is up to recent industry standards of sterilization, charting and patient safety. After a visit is completed, results and any improvement opportunities will be shared with you. A sample assessment form follows.

CONNECTICUT DENTAL HEALTH PARTNERSHIP

FACILITY/RECORD REVIEW
Part A

Date: _____

Rep: _____

TIN: _____ PRACTICE TYPE: _____ PHONE: _____

DENTIST/PRACTICE NAME: _____

OFFICE ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CROSS STREETS/TRAVEL INFO: _____

COUNTY: _____ EMAIL: _____ FAX: _____

FACILITY: ☐PROFESSIONAL BLDG ☐ STORE FRONT ☐HOUSE ☐APARTMENT ☐W/C ACCESSIBLE # OF OPS _____

HOURS: SUN _____ MON _____ TUES _____ WED _____ THURS _____ FRI _____ SAT _____

SPECIALISTS:

- ☐ ENDODONTIST _____
- ☐ ORAL SURGERY _____
- ☐ ORTHODONTIST _____
- ☐ PEDODONTIST _____
- ☐ PERIODONTIST _____

GENERAL DENTISTS:

_____

_____

_____

OFFICE MANAGER: _____

HYGIENIST: ☐ YES ☐ NO

LANGUAGES: ☐SPANISH ☐RUSSIAN ☐CANTONESE ☐MANDARIN ☐KOREAN ☐HINDI ☐ARABIC ☐OTHER _____

SPECIAL SERVICES: ☐ TTY/TDD ☐BRAILLE ☐LARGE PRINT MATERIALS ☐OTHER _____

SECTION	DESCRIPTION	YES	NO	N/A	WEIGHT	SCORE
A.	**GENERAL OFFICE INFORMATION (30)**					
01.	Office sign easily identifiable				1	
02.	Well marked exits				1	
03.	A No Smoking policy is maintained				3	
04.	After hours answering mechanism in place				5	
05.	Overall appearance neat and clean				20	
B.	**RECEPTION/WAITING ROOM (15)**					
06.	Courteous receptionist				3	
07.	Entertaining/education material is available				1	
08.	Adequate seating is available				1	
09.	Area is neat and clean				10	
C.	**RADIOLOGY (40)**					
10.	Current inspection and certification is displayed				5	
11.	Lead apron in satisfactory condition and used routinely				30	
12.	Thyroid collar available				5	
D.	**OPERATORIES (44)**					
13.	Ability to treat patient in a wheelchair				0	
14.	Chair and light barrier changed between patients				3	
15.	Prescription pads are not patient accessible				2	
16.	Sterile/disposable products used appropriately				3	
17.	Waste cans have lids				1	
18.	Equipment appears clean and in good order				10	
19.	Operatories are free of clutter				5	
20.	Operatories are free of dust/dirt				10	
21.	Operatories are organized for safety				10	
E.	**STERILIZATION/DISINFECTION (150)**					
22.	Autoclave/Chemiclave/Dry Heat is used on appropriate materials				50	
23.	Instruments are scrubbed before sterilization				3	

24.	Instruments wrapped/process indicators used				4	
25.	Handpieces are sterilized after each use or disposed				50	
26.	Burs/files sterilized after each use or disposed				20	
27.	High level disinfection used on all items that cannot be heat sterilized				10	
28.	Clean/Dirty areas are separate				3	
29.	Spore testing is done weekly and log is available				10	
F.	**SAFETY (20)**					
30.	Eye wash station is operational				3	
31.	Material Safety Data Sheets are kept in a file				1	
32.	OSHA labeling requirements adequate				3	
33.	Puncture resistant container used for discarding needles and sharps				3	
34.	Hazardous waste is marked and stored properly				3	
35.	Office is using a certified/bonded carrier to remove hazardous waste				2	
36.	Needles are recapped				3	
37.	Eye protection is offered to patient				2	
G.	**INFECTION CONTROL (32)**					
38.	Surgical gloves worn routinely and changed for each patient				15	
39.	Antimicrobial soap is used in operatories				3	
40.	Face masks worn by all patient care personnel				3	
41.	Headrest covers used				3	
42.	Hepatitis B Virus (HBV) vaccination is offered to all staff or waivers signed				3	
43.	EPA approved solutions are used to wipe down surfaces				5	
H.	**EMERGENCY PREPREDNESS (13)**					
44.	Fire extinguisher is accessible				2	
45.	Portable oxygen tank is present				2	
46.	Basic medical emergency kit is present and medications are current				3	
47.	Dentist's CPR certification is current				3	
48.	Office has documented emergency protocol				3	
I.	**ANESTHESIA/SEDATION**					
49.	Nitrous oxide and/or GA is available				0	
50.	Nitrous oxide has a scavenger system				3	
51.	Oxygen and nitrous tanks are chained				2	
52.	Inhalation masks sterilized if not disposable				5	
J.	**LABORATORY (15)**					
53.	Clean and uncluttered				5	
54.	Disposable or sterilized impression trays				5	
55.	Wheel disinfected/pumice changed between patients				5	
K.	**PATIENT RESTROOM (7)**					
56.	Restroom is handicap accessible				1	
57.	Waste can has lid				1	
58.	Restroom is clean and well maintained				5	

Total Score of Facility Review _____

Total Points 376

Less Not Applicable Points _____

Total Points Available _____
(Total points less Not Applicable Points)

Facility Review Percentage _____
(Total Score/Total Points Available)

SCORING

A minimum of 300 points is required to pass this section.

PERCENTAGE	
Excellent	100-96
Good	95-90
Fair	89-80
Fail	Below 80

FACILITY/RECORD REVIEW - Part B

L.	RECORDS MANAGEMENT (14)	YES	NO	N/A	WEIGHT	SCORE
59.	Confidentiality, security and physical safety of records is maintained				3	
60.	Individual records for each patient				3	
61.	Each page record is labeled				2	
62.	Consent forms maintained in patient record, signed by patient/Resp. Party				3	
63.	Records are retained at least 7 years				3	
M.	**RECORD STRUCTURE (62)**					
64.	Patient medical history annual update(min) documented & signed by pt				5	
65.	Health history signed by dentist upon review				5	
66.	Medical conditions prominently noted				5	
67.	Medication(s) allergies and adverse reactions prominently noted in pt record				5	
68.	Periodontal evaluation documented				3	
69.	Intraoral cancer screening noted				5	
70.	Appropriate type(s) and number(s) of current radiographs maintained in record				3	
71.	Physical/oral findings are documented				3	
72.	Every entry is dated				3	
73.	Entries are legible/recognized by staff				3	
74.	Each entry signed/initialed				3	
75.	Entries in ink				3	
76.	No spaces or white-out				3	
77.	Local anesthesia or drug name and dosage noted				3	
78.	Notation of broken appointments and follow-up are included in patient record				3	
79.	Treatment plans are noted				2	
80.	Treatment plans are completed				2	
81.	Adherence to proper plan billing (profiles)				3	
N.	**PREVENTIVE DENTAL SERVICES (10)**					
82.	Patient education is documented				3	
83.	Recall system documented				4	
84.	Sealants routinely applied as appropriate				3	

Total Score of Record Review _____

Total Points 86

Less Not Applicable Points _____

Total Points Available _____

(Total points less Not Applicable Points)

Record Review Percentage _____

(Total Score/Total Points Available)

SCORING

A minimum of 65 points is required to pass this section.

PERCENTAGE	
Excellent	100-96
Good	95-90
Fair	89-75
Fail	Below 75

Facility Review ☐Pass ☐Fail **Record Review** ☐Pass ☐Fail TIN:_____

OVERALL RESULT ☐**PASS** ☐**FAIL** (**A passing grade is required in both sections**)

Comments:_____

_____

Follow-Up: ☐1 month ☐3 months ☐6 months ☐1 year ☐Other _____

Reviewer Signature:_____ Date:_____

Dentist Signature:_____ Date:_____

Quality Assurance Review Supervisor:_____ Date:_____

Thank you for participating in our Quality Assurance Program. In an effort to assist your office in achieving the highest practice standards, our Quality Assurance representative has reviewed the following standards with you and/or your office staff.

SECTION	ITEM	STANDARD	CORRECTIVE ACTION PLAN
A. GENERAL OFFICE INFORMATION	01.	The dental office can be identified for patient accessibility.	Post an identifiable sign on the building and/or at street side.
	02.	All exits must be marked with a sign of such size, color, and design that is clearly visible to assist personnel in its location. (OSHA)	A sign must be posted at each facility exit. The sign must be distinctive in color and provider contrast from decorations.
	03.	A written NO-SMOKING policy is in place.	Implement a written NO-SMOKING policy.
	04.	An answering machine or service is available for patients to get instructions in case of an emergency or to leave a message.	Install an answering machine with appropriate instructions on emergency.
	05.	Outside and inside appearance of office demonstrates facility is maintained in a safe and clean condition.	Establish routine housekeeping function policy and assure that these are performed on a regular basis.
B. RECEPTION/ WAITING ROOM	06.	A courteous, professional staff member should greet patients.	Receptionist/staff should be trained to properly welcome and address patients.
	07.	Wait area should be comfortable and offer reading material. If younger patients are routinely seen, appropriate materials should be available for their age.	Add current reading material and music or TV for patient entertainment.
	08.	Adequate seating should be available to accommodate waiting patients and companions.	Additional seating accommodations are to be provided.
	09.	Wait area appearance demonstrates facility is maintained in clean and neat condition.	Establish routine housekeeping function policy and assure that these are performed on a regular basis.
C. RADIOLOGY	10.	X-ray equipment should have current registration. (CTDHP)	Contact the State to obtain current registration and inspection.
	11.	Proper shielding of patients should include a full size lead apron.	Purchase and utilize the necessary lead shield.
	12.	Proper shielding of patients should include a thyroid collar.	Purchase and utilize the necessary collar.
D. OPERATORIES	13.	Operatories should be accessible to patients with disabilities. (Americans with Disabilities Act)	At new construction or remodeling, wheelchair accessibility and treatment should be considered.
	14.	All chair and light coverings should be changed between patients. (CDC)	Establish routine policy to change chair and light barrier coverings between patients.
	15.	Prescriptions pads should not be patient accessible.	Store all prescription pads in area that is not accessible by patients.
	16.	Disposable products must be disposed of after use on a patient. Disposables may not be reused or sterilized. (CDC)	Purchase sufficient supplies and implement a policy so that all disposables are properly disposed of after use on a patient.
	17.	Waste cans should have lids so discarded items are not readily available to patients or companions.	Provide a covered waste container.
	18.	All equipment must be in good working order and wiped clean between patients.	A policy for cleaning equipment routinely must be implemented and equipment must be repaired or replaced or discarded.
	19.	Patient supplies should not be stored on counter tops or on the floor.	All patient supplies are to be removed from the floor and counter tops in patient areas.
	20.	Area must be clean. (ADA)	Establish routine housekeeping function policy and assure that these are performed regularly.
	21.	Area should be free of hazardous conditions (ie. hanging wires, broken floor tiles, easily accessible solvents). (CTDHP)	Repair and/or reorganize room, equipment and supplies for greater safety.
E. STERILIZATION & DISINFECTION	22.	Instruments are to be sterilized by autoclave. (ADA, CDC)	Autoclave is to be used.
	23.	Prior to sterilization instruments must be scrubbed in order to remove debris. (CDC)	Instruments are to be scrubbed and placed in ultrasonic prior to sterilization.
	24.	Instruments should be wrapped and marked with the date of sterilization and used within 6 months. (CDC)	Wrap, date and sterilize all loose instruments.
	25.	Handpieces should be wrapped and heat sterilized between use on patients. (CDC, ADA)	Wrap and sterilize handpieces. Handpieces are to be stored in wraps until use.
	26.	All cutting burs and files must be sterilized or disposed of after use. (CDC)	Burs/files must be sterilized or disposed of after use.
	27.	A cold sterilization solution must be used to disinfect any items that cannot be heat sterilized and are not disposable. (CDC)	A high level disinfection sterilization solution must be used.
	28.	Dirty equipment should not be cleaned and processed in the same area that is used for clean instruments due to infection control concerns. (CDC)	Signs should be posted to separate clean and dirty areas to prevent cross contamination of materials or equipment.

	29.	Weekly spore testing on the autoclave or chemiclave is mandatory to ensure proper conditions for sterilization. Logs must be maintained for spore testing dates and test results. (ADA)	Implement weekly spore testing. A log of test results must also be maintained.
F. SAFETY	30.	Provisions for emergency eye wash are available. The office eyewash station should be maintained in proper working order. (OSHA)	Eye wash station must meet OSHA criteria Eye wash station sign must be posted and visible.
	31.	MSDS need to be available for all chemical products used in the office. These should be maintained in a binder and updated annually. MSDS can be obtained through the product manufacturer.	MSDS need to be current and available for reference.
	32.	All chemicals are appropriately labeled so that they may be easily identifiable and warnings are apparent for poisonous material. (OSHA)	All chemicals are to be labeled as per OSHA requirements.
	33.	A puncture resistant container is used to discard sharps. (CDC)	Puncture resistant container must be used for discarding sharps.
	34.	A large biohazard container with a lid is used to store biohazard materials. These must be disposed of properly and in accordance with OSHA and State regulations.	Designate and label properly containers for biohazard materials in accordance with State regulations and OSHA. Red bags or red sharps containers may be an acceptable practice per local requirements.
	35.	A certified/bonded carrier is used to remove infectious waste. A log is maintained of infectious waste removal. (CDC)	Contract with a certified/bonded carrier to remove infectious waste.
	36.	Needle must be recapped during treatment and disposal to avoid contamination and puncture accidents.	Implement a policy to recap all needles during treatment and disposal.
	37.	Safety glasses with side shields are provided for all clinical staff and patients. (CDC, OSHA)	Purchase safety glasses with side shields for all clinical staff and patients.
G. INFECTION CONTROL	38.	Appropriate personal protective equipment (PPE) and gloves must be utilized. A new pair of gloves must be worn for each patient and remain in the treatment area only. (DCD, OSHA)	Purchase gloves for use by dentist and staff. Implement a policy that new gloves be worn for each patient.
	39.	Antimicrobial soap used in operatories. (CDC)	Hands should be washed with an antibacterial, antimicrobial soap before gloving and after each patient.
	40.	Masks should be used with each patient when splatter is anticipated. (CDC, OSHA)	Purchase masks for use by dentist and staff. Implement a policy that masks should be changed between each patient or when soiled.
	41.	Headrest covers are to be used. (CDC)	All protective coverings should be changed between each patient.
	42.	Each employee with potential exposure must be offered immunization against Hepatitis B at the employer's expense. Employees may refuse vaccination but must sign an informed consent of declination.	Provide all appropriate staff with employer paid immunization against Hepatitis B immediately. Maintain signed informed consent for refusals.
	43.	Equipment surfaces should be sprayed between each patient with an anti-microbial agent using the spray-wipe method. (CDC)	EPA approved solutions shall be purchased and used as indicated.
H. EMERGENCY PREPAREDNESS	44.	Office should be equipped with current fire extinguisher. (CTDHP, OSHA)	Fire extinguishers should be mounted in easy to reach areas, fully charged and operational at all times and inspected regularly.
	45.	Emergency oxygen tank must be available and monitoring documented.	Purchase a portable oxygen unit and place in an accessible area. The unit must have an expiration date tag attached.
	46.	Office should have emergency first aid kit with life sustaining drugs. Emergency drug kit should be kept inaccessible to patients. (OSHA)	Emergency first aid kit should be obtained and emergency drug kit checked regularly for expired drugs.
	47.	CPR certification is required by dentist and/or full time employee. (OSHA)	At least 1 full time staff member will be CPR certified.
	48.	Office has documented emergency protocol. (OSHA)	Create and document emergency protocol.
I. ANESTHESIA / SEDATION	49.	Office should have appropriate monitoring equipment if anesthesia is available.	Anesthesia/analgesia monitoring equipment is to be used.
	50.	If nitrous oxide analgesia is used, a scavenger system must be used: it is the law. Tubing must be free of cracks or perforations.	A nitrous oxide scavenger system must be installed.
	51.	Tanks must be mounted securely to prevent an accident.	Tanks must be secured.
	52.	Masks are to be sterilized for each patient. (CDC)	Sufficient masks must be available to allow for sterilization between patient uses.
J. LABORATORY	53.	Laboratory should be clean and well organized. (CDC)	Establish routine housekeeping function policy and assure that these are performed regularly.
	54.	Impression trays must be sterilized between patient use or disposable trays may be used. (CDC)	Impression trays are to be sterilized and stored in bags or purchase disposable impression trays to be used appropriately.
	55.	All materials used in the laboratory that come in contact with dental prosthesis must be disinfected after each use. (CDC)	Ragwheels and brushes should be disinfected or heat sterilized after each use.

K. PATIENT RESTROOMS	56.	Restrooms should be equipped for patients with disabilities. (Americans with Disabilities Act)	Upon remodeling or new construction, restroom should be made handicap accessible.
	57.	A covered waste container should be located in the restroom.	A covered waste container must be provided.
	58.	Restroom is clean and well maintained. (CDC, OSHA)	Establish routine housekeeping function policy and assure that these are performed regularly.
L. RECORDS MANAGEMENT	59.	All dental records should be maintained and secured at your facility in a place that assures confidentiality and physical safety. These records should not be stored in a place where visitors or patients have accessibility. (HIPAA)	Store patient records in an area that is not readily accessible to patients and inappropriate staff members.
	60.	Individual records for each patient. (CTDHP)	Each patient should have an individual dental record that is clearly labeled.
	61.	Each page of the dental record should be clearly labeled with patient identification. (CTDHP)	Place patient identification on each page of the patient's dental record in order to maintain the records in the appropriate chart.
	62.	For risk management purposes, signed consent forms should be maintained in the dental record and updated on an annual basis.	Develop consent forms and maintain in dental record. Update the consent forms on an annual basis.
	63.	A policy for retaining charts at least 6 years after the last date of service.	Retain dental record for a minimum of 6 years after the last date of service.
M. RECORD STRUCTURE	64.	Medical history is updated and signed on annual basis.	Update the medical history at least annually.
	65.	Health history is signed by dentist upon review. (CTDHP)	Dentist shall review sign and date medical history.
	66.	Medical conditions/treatment requiring specific attention relating to dental treatment is flagged in the record. (CTDHP)	Prominently display medical alert conditions.
	67.	Medications, allergies and adverse reactions are prominently noted in the record. (CTDHP)	Prominently document allergies, adverse reactions and medications.
	68.	A periodontal evaluation is usual practice to establish baseline oral conditions. (ADA)	Document complete periodontal charting of pocket depths as part of the initial baseline data.
	69.	An intraoral screening is done to fulfill basic requirements of a complete examination. (ADA)	Document examination of intraoral structures and tissues.
	70.	Appropriate type(s) and number(s) of current radiographs are evident to fulfill basic requirements for a complete patient examination. (CTDHP)	Utilize the guidelines published by the Dept. of Health and Human Services, Center for Devices and Radiological Health.
	71.	Objective data and physical/oral examination findings are documented as related to the patient's chief complaint. (CTDHP)	Document symptoms, onset, duration, frequency and/or severity of the chief complaint(s).
	72.	Entries made in the dental record are dated with month, date and year of entry. (CTDHP)	Document the date, month and year of all dental record entries.
	73.	Dental records must be legible, documented accurately in a timely manner, and readily accessible to health care practitioners. (CTDHP)	Document in a legible manner. Staff and other health care providers should be able to read the documentation.
	74.	Chart entries made by the dentist or the staff must be signed and dated. (CTDHP)	Sign or initial and date each chart entry.
	75.	Entries should be made in ink to ensure complete, legible and accurate record keeping. (CTDHP)	Use ink when making entries on patient chart/record.
	76.	Spaces or use of white out in record keeping is not acceptable. (CTDHP)	Do not use white out or leave spaces in patient records.
	77.	Type and dosage/amount of local anesthetic used must be documented in the record. (CTDHP)	Document the type and dosage/amount of local anesthetic used.
	78.	If patient fails to keep appointment, there should be a notation in the dental record of the follow-up that was done.	Document missed appointments in the dental record.
	79.	A written treatment plan, including treatment options discussed must be documented in the record. (CTDHP)	Document treatment plan and options, if applicable.
	80.	Follow-up care for completion of treatment plan including consultations, referrals and return to office dates should be documented. (CTDHP)	Document the time intervals, purpose for the next appointments and completion of treatment plan in patient record.
	81.	Follow plan guidelines related to billing members for covered services.	Adhere to proper plan billing profiles.
N. PREVENTIVE DENTAL SERVICES	82.	Any form of patient education, such as literature, brochures, verbal instruction or demonstration should be documented.	Document all forms of patient education.
	83.	A complete oral exam should be offered to each established adult or pediatric patient on an annual or biannual basis. (ADA)	Document recall interval and efforts to schedule an appointment.
	84.	As appropriate, sealants should be routinely applied. (ADA)	Apply sealants as appropriate.

References: CDC: Center for Disease Control, Department of Health &Human services, "Practical Infection Control in the Dental Office", October 2003; ADA: American Dental Association, ADA Council on Sci. Affairs & ADA Council on Dental Practice, "Infection Control Recommendations for the Dental Office & the Dental Laboratory", October 1999; OSHA: Occupational Safety & Health Administration; American with Disabilities Act of 1990; CTDHP: Connecticut Dental Health Partnership recommendation

Marketing Guidelines

All marketing materials used for the CT Dental Health Partnership must be reviewed and approved by CTDHP and the Department of Social Services prior to use. Please submit a copy of your proposed materials for review to:

Connecticut Dental Health Partnership
Senior Director of Network Development
PO Box 486
Farmington, CT 06032-0486

CTDHP and the Department of Social Services (DSS) will review materials submitted for approval and respond to review requests within sixty (60) days. If DSS does not respond to materials submitted for approval within sixty (60) days, the provider, provider group, facility or its representative(s) (referred to as "Providers" going forward) may use the materials as presented. CTDHP or DSS reserves the right to request revisions or recall any materials that advertise or represent State or Departmental program(s) in advertisements or specific materials at any time.

The following guidelines apply to marketing your services to CTDHP members (HUSKY Health or Covered CT Members). Please read them carefully.

Outreach Materials

All providers (individual providers, groups, facilities or programs) that provide dental services to Connecticut Dental Health Partnership HUSKY Health or Covered CT members must obtain prior approval from the Department of Social Services for all marketing activities, health education and all other materials.

Marketing materials that contain outreach information which targets CTDHP members (HUSKY Health or Covered CT Members):

Annual marketing plans and revisions to these plans as they concern CTDHP clients are subject to review. Submissions should include a description of the proposed marketing approaches, strategies, tactics and channels..

The State of Connecticut, Department of Social Services or any program logos and names in private marketing materials which target CTDHP clients are conditionally permitted. The program logo may be used in conjunction with and must be placed in the vicinity of the provider/provider's office name. The font size for the statewide program phone number must not be smaller than the facility or provider's office phone numbers.

Any alternative language including non-English translations must be prior approved by the Department of Social Services.

Corporate marketing materials that include the Department of Social Services' programs do not require prior approval if the materials exclusively promote the corporate brand and do not mention CTDHP, HUSKY Dental or any State of Connecticut or Departmental programs.

Truthful and Accurate Materials

All marketing materials must be truthful and accurate. Providers may not promote their offices through misleading, inaccurate or deceptive electronic, audio, printed or artistic materials. The Department of Social Services will not allow any information that it determines to be misleading or exaggerated. This includes inaccurate statements regarding an individual's eligibility, enrollment or program benefits, the positive attributes of the office/facility, or disadvantages of competing providers or facilities.

Providers or their representatives must not present misleading or exaggerated claims about themselves,
their offices or facilities' positive attributes. Misleading references include advertisements that a provider's services are free to any state, "Medicaid" or CTDHP members (HUSKY Health or Covered CT Members).

Prospective clients could conclude from advertisements of this nature that only this particular provider/facility provides services or free services to CTDHP members (HUSKY Health or Covered CT Members. Providers/facilities may distinguish themselves by promoting their legitimate positive attributes. Providers may not present false or misleading statements that any of their products are endorsed by the Department of Social Services or the Center of Medicare and Medicaid Services (CMS) or any other government entity. Providers are also restricted from engaging in deceptive, fraudulent or abusive practices for any purpose including enticing a client to become a patient and change their dental home.

Providers may not discriminate against any eligible individual on the basis of race, sex, age (including pediatric practices or facilities in the circumstances of older patients with special cognitive needs), creed, oral health status or the need for future oral health care services. In addition,
discrimination based on sexual orientation; and gender identity and expression, is prohibited under state law.

Marketing Staff

The provider must not compensate marketing staff whether they are employees, independent contractors or marketing representatives through the use of a per client/patient incentive or a similar bonus type of reimbursement. Policies and procedures must be implemented to manage actions of the marketing staff to ensure compliance with these marketing guidelines. These guidelines must be distributed to all of a provider's offices and must require that the guidelines be followed at all offices located in Connecticut or in offices deemed to be "border town" offices or "out of state" practices. Providers may display DSS approved materials and brochures in their offices. All unapproved materials are mandated to be retracted.

Recruitment or Solicitation of New Patients

Providers or their representatives may not actively solicit new patients at other provider sites, offices or facilities. Marketing and solicitation materials may not be distributed at DSS eligibility offices, including those in hospitals or other facilities for the purpose of marketing or solicitation. Providers may provide their materials to the DSS Central Office which will distribute the materials to regional operational centers for display purposes.

Providers may not market or promote their services through any means of telemarketing, mass mailings or any other means by which they may establish unsolicited personal contact with potential CTDHP members (HUSKY Health or Covered CT Members). Providers are permitted to respond with allowed information to unsolicited phone calls from potential clients or patients and may return calls to them when they request a return call. The provider may also provide DSS-approved materials when requested by a potential patient. Providers may distribute marketing materials to its service area, but may not conduct personal, small group or face-to-face marketing meetings except as provided below.

Recruitment or Solicitation of New Patients through Events

Providers may not conduct promotional group meetings or individual solicitation with potential patients at provider offices or group offices, private clubs, private residences or employer sites. Providers may conduct outreach or market their services at events and meetings which are open to the general public including those held at public facilities, churches, health fairs, other community sites and those organized or sponsored if the provider notifies DSS in advance of such meetings by submitting to DSS on a monthly basis the schedules of educational and marketing events for the following month. The schedules must contain enough information to allow DSS to attend events and monitor for compliance. Providers must utilize DSS approved materials in the presentations and comply with DSS's marketing guidelines. Providers may only request name, address, phone number and family size from potential patients. Providers are not allowed at any time to request Social Security Number, date of birth, Client Identification Number, children's names, family member names that are related to family members or future potential patients.

Gifts, Tokens and Incentives to Patients

The provider must not under any circumstances request or require personal contact information of potential patients in return for any gift item. Providers may distribute promotional token gifts of nominal value (toothbrushes, sample dental floss, magnets, pens, bags, etc.) at approved events and with approved materials to potential patients when DSS has approved the materials in advance of the distribution and the unit cost value of each item is less than two dollars ($2.00) and the aggregate cost per potential client shall not knowingly exceed four dollars ($5.00) per occasion.

Providers may provide the following materials to CTDHP members (HUSKY Health or Covered CT Members) who are patients of record when DSS has approved the items and criteria for distribution:

- Token gifts to members including magnets, phone labels, and other nominal items that promote the dental providers services to reinforce "good" dental practices or behaviors.
- Welcome packets sent to new patients of record.
- Oral Health education materials which include but are not limited to podcasts, videos, CDs, DVDs, and other media.

Providers must not provide or sponsor incentives unless explicitly approved by DSS. Such incentives include but are not limited to:

- Cash or gifts, including gift certificates or cards, to clients, patients of record or potential patients.
- Gifts of any kind to agencies including DSS or its designee that hosts meetings with clients or potential patients.
- Raffles in association with marketing related activities or for the purpose of collecting information for future marketing activities for potential patients.
- Offering free screening and/or examinations and/or other dental services to potential or future patients or soliciting referrals from patients of record.

Providers are encouraged to remind patients to utilize benefits including regular examinations and cleanings which are available and designed to promote good oral health at periodic regularly scheduled appointments. The provider may disseminate information solely regarding general oral health information materials to their patients of record without prior approval from DSS.

Utilization Management Programs

Utilization Management (UM) is a set of processes which seeks to ensure that eligible members receive the appropriate, least restrictive and most cost-effective treatment to meet their identified oral health needs within the prevailing standards of care. Utilization Management as used in this context includes practices such as, prior authorization, concurrent claims review, retrospective medical necessity review and retrospective utilization review.

Prior authorization includes prospective and concurrent claims review to ensure that services are delivered in accordance with the programs coverage guidelines, benefit rules and prevailing community standards of care. Retroactive medical necessity review may include provider chart reviews to ensure that documentation supports medical necessity and medical appropriateness of services and treatments rendered and that the documentation is consistent with the provider's claims. These chart reviews may be random or targeted based on information produced during the utilization management process.

BeneCare has developed a sophisticated proprietary, multi-variable statistical approach to utilization management which seeks to explain an individual dentist or practice's divergence from the average activity of all participating dentists by client group. The algorithm includes consideration of such factors as the age and gender mix of patients seen, the doctor's year of licensure, specialization or general practice, the socio-economics of the practice's location and

other variables. Utilization reports are generated for each dentist or practice that compares the dentist's profile with the group norm.

Expected procedure frequencies are tabulated for every category of care, against which each dentist is measured. The profile highlights instances of both under and over-treatment when compared to the expected norm for the group using standard statistical measurement techniques.

Utilization management analyses are conducted periodically. Practitioners' average care costs per patient are compared to the average cost of care for all patients under each dental specialty to further inform service distribution and practice pattern profiles. When a dentist's utilization patterns are outside of the confidence interval limits calculated in the statistical model or their average costs per patient are in variance to the average costs per patient generally, a more detailed utilization management investigation may be conducted.

Based upon these findings, communications from CTDHP detailing the variance in practice patterns or care costs and detailing the areas of concern will be sent to practitioners requesting a response that either explains the variance from expected norms or affirms an understanding of the areas of concern and agreement to modify practice patterns which led to the observed outcomes.

Non-compliance with these communications efforts may lead to further corrective action being initiated, which may include:

- Random or selected chart audits
- Referral to the Department of Social Services Quality Assurance Unit
- Practitioner specific modifications to future prior authorization and claims review requirements
- Terminating the dentist from the network

Sample UM Reporting

SUMMARY UTILIZATION AND PROCEDURES REPORT
FOR PERIOD FROM 3/01/2010 TO 8/31/2010
SPONSOR NUMBER: XXXXXX
SPONSOR NAME: GROUP ABC

DR. DENTIST ID: 123456789 Specialty: Pediatric Avg. Care Cost Per Patient: $239.88

	Number of Patients	Num of Patient Visits	Num Married Pats	Num of Male Pat	Patient Counts By Relationship: Parts	Spouses	Child	Ave Family Size	Patient Counts By Age: 0-14	15-34	35-54	55+	Ave Age	Median Age
Dr's Activity	4,278	5,503	0	2,145	4,278	0	0	1	3,785	492	1	0	8	8
Sponsor's Activity	96,379	146,482	2	39,937	96,379	0	0	1	54,277	27,931	13,446	725	13	11

	Sponsor's Actual Activity			Dentist Actual Activity			Dentist Estimated Activity				
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]
Procedure Code Group	Number of Procedures	Percent of Total	Number Per 100 Patients	Number of Procedures	Percent of Total	Number Per 100 Patients	Range-Lower Limit	Expected Number Procedures	Range-Upper Limit	Factor By Which Act/ Exp. Differ	Actual Compared To Limits
PERIODIC EXAM	57,874	47.61	60.04	3,240	15.72	75.73	66.00	75.00	84.00	0.00	WITHIN
LMT ORAL EVAL	18,749	90.21	19.45	250	1.21	5.84	6.00	9.00	12.00	0.64	UNDER
COMP ORAL EVAL	26,599	13.80	27.59	662	3.21	15.47	15.00	23.00	31.00	0.00	WITHIN
RE EVAL LMT'D	7	0.02	0.00	1	0.00	0.02	25.00	34.00	43.00		N/A
COMP XRAY SERIES	3,728	15.95	3.86	13	0.06	0.30					N/A
PERIAPICAL XRAYS	79,647	40.76	82.63	558	2.70	13.04	11.00	45.00	80.00	0.00	WITHIN
OTHER XRAYS	593	2.53	0.61	43	0.20	1.00	15.00	26.00	36.00	0.03	UNDER
BW XRAYS	46,973	0.97	48.73	1,488	7.22	34.78	30.00	37.00	45.00	0.00	WITHIN
PANORAMIC XRAY	15,864	67.87	16.46	408	1.98	9.53	7.00	11.00	14.00	0.00	WITHIN
ADULT PROPHY	18,263	78.13	18.94	38	0.18	0.88					N/A
CHILD PROPHY	63,742	72.71	66.13	4,012	19.47	93.78	79.00	91.00	102.00	0.00	WITHIN
FLOURIDES	60,903	60.56	63.19	4,152	20.15	97.05	78.00	90.00	102.00	0.00	WITHIN
SEALANT TOOTH	54,467	33.03	56.51	1,765	8.56	41.25	38.00	57.00	76.00	0.00	WITHIN
SPACE MAINTAINERS	1,172	5.01	1.21	123	0.59	2.87	1.00	4.00	7.00	0.00	WITHIN
AM 1 SURF	4,550	19.46	4.72	69	0.33	1.61					N/A
AM 2 SURF	6,709	28.70	6.96	415	2.01	9.70					N/A
AM 3 SURF	2,369	10.13	2.45	110	0.53	2.57					N/A
AM 4 SURF	467	1.99	0.48	8	0.03	0.18					N/A
COMP 1 SURF	4,049	17.32	4.20	105	0.50	2.45	2.00	4.00	7.00	0.00	WITHIN
COMP 2 SURF	3,296	14.10	3.41	85	0.41	1.98	2.00	4.00	6.00	0.49	UNDER
COMP 3 SURF	4,870	20.83	5.05	128	0.62	2.99					N/A
4S RSN COM	3,940	16.85	4.08	65	0.31	1.51	1.00	5.00	9.00	0.00	WITHIN
1 S RSN COM POS	32,158	37.58	33.36	521	2.52	12.17	14.00	25.00	36.00	0.48	UNDER
2S RSN COM POS	31,790	36.01	32.98	403	1.95	9.42	16.00	26.00	36.00	0.36	UNDER
3S RSN COM POS	16,640	71.19	17.26	76	0.36	1.77	2.00	9.00	16.00	0.19	UNDER
4S RSN COM POS	4,598	19.67	4.77	8	0.03	0.18					N/A
CROWNS/STNLS	5,028	21.51	5.21	270	1.31	6.31					N/A
SEDATIVE REST	1,245	5.32	1.29	11	0.05	0.25					N/A
PULP CAPS	1,441	6.16	1.49	24	0.11	0.56					N/A
PULPOTOMY	3,282	14.04	3.40	249	1.20	5.82	2.00	11.00	20.00	0.00	WITHIN
PERIO SURGICAL	137	0.58	0.14	1	0.00	0.02					N/A
SIN TOOTH EXT	15,789	67.55	16.38	527	2.55	12.31	8.00	19.00	31.00	0.00	WITHIN
EMER TREATMENT	477	2.04	0.49	4	0.01	0.09					N/A
GENERAL ANESTHESIA	6,212	26.57	6.44	772	3.74	18.04	1.00	4.00	7.00	4.51	OVER

AREAS OF CONCERN:

1.) General Anesthesia at 4.5 times the frequency for the group.

SPONSOR CLAIM REVIEW: ABCDE
FOR CLAIMS PAID FROM 3/01/2010 TO 8/31/2010

PEDIATRIC DENTSITS

DENTIST ID	DENTIST NAME	NBR OF PATIENTS	NBR OF CLAIMS	TOTAL DOLLARS	AVE PER CLAIM	AVE PER PATIENT	ACCP Compared to Limits	AMT VAR From Average	PCT VAR From Average
983685596	DR. 983685596	1	2	$960.00	$480.00	$960.00	Over	$570.40	246.41%
780891724	DR. 780891724	5	9	$2,365.00	$262.77	$473.00	Within	$83.40	121.41%
922346852	DR. 922346852	33	57	$7,611.00	$133.52	$230.63	Under	($158.97)	59.20%
499796318	DR. 499796318	50	129	$21,773.26	$168.78	$435.46	Within	$45.86	111.77%
438035974	DR. 438035974	64	123	$105,557.64	$858.19	$1,649.33	Over	$1,259.73	423.34%
198810596	DR. 198810596	68	114	$14,397.00	$126.28	$211.72	Under	($177.88)	54.34%
642225734	DR. 642225734	86	161	$28,165.00	$174.93	$327.50	Within	($62.10)	84.06%
968666039	DR. 968666039	101	154	$28,481.52	$184.94	$281.99	Under	($107.61)	72.38%
245275678	DR. 245275678	164	264	$63,462.80	$240.38	$386.96	Within	($2.64)	99.32%
669169897	DR. 669169897	207	408	$47,801.00	$117.15	$230.92	Under	($158.68)	59.27%
799745975	DR. 799745975	248	410	$63,327.04	$154.45	$255.35	Under	($134.25)	65.54%
753216082	DR. 753216082	255	387	$87,048.91	$224.93	$341.36	Within	($48.24)	87.62%
287115402	DR. 287115402	280	583	$116,323.17	$199.52	$415.43	Within	$25.83	106.63%
533498461	DR. 533498461	284	400	$59,281.00	$148.20	$208.73	Under	($180.87)	53.58%
485263065	DR. 485263065	287	466	$87,194.00	$187.11	$303.81	Within	($85.79)	77.98%
801031574	DR. 801031574	369	554	$89,397.30	$161.36	$242.26	Under	($147.34)	62.18%
776896610	DR. 776896610	385	570	$81,277.95	$142.59	$211.11	Under	($178.49)	54.19%
796656311	DR. 796656311	568	878	$154,344.70	$175.79	$271.73	Under	($117.87)	69.75%
477641548	DR. 477641548	576	862	$135,601.07	$157.30	$235.41	Under	($154.19)	60.42%
201563419	DR. 201563419	580	822	$125,859.00	$153.11	$216.99	Under	($172.61)	55.70%
222406485	DR. 222406485	585	927	$188,704.00	$203.56	$322.57	Within	($67.03)	82.80%
925430083	DR. 925430083	648	1,231	$287,522.80	$233.56	$443.70	Within	$54.10	113.89%
841433100	DR. 841433100	838	1,457	$254,795.80	$174.87	$304.05	Within	($85.55)	78.04%
495860242	DR. 495860242	928	1,475	$348,505.56	$236.27	$375.54	Within	($14.06)	96.39%
112836448	DR. 112836448	1,080	1,551	$492,117.18	$317.29	$455.66	Within	$66.06	116.96%
759562509	DR. 759562509	1,520	3,023	$761,534.68	$251.91	$501.00	Over	$111.40	128.59%
397646964	DR. 397646964	1,541	2,517	$546,141.68	$216.98	$354.40	Within	($35.20)	90.97%
267086699	DR. 267086699	1,614	3,135	$978,216.39	$312.03	$606.08	Over	$216.48	155.57%
278764809	DR. 278764809	1,757	3,137	$663,195.00	$211.41	$377.45	Within	($12.15)	96.88%
145947747	DR. 145947747	2,363	3,593	$490,371.60	$136.47	$207.52	Under	($182.08)	53.27%
326585986	DR. 326585986	4,338	6,261	$1,040,636.49	$166.20	$239.88	Under	($149.72)	61.57%

PARTICIPATING DENTISTS SERVICES	21,823	35,660	$7,371,969.54	$206.73	$337.81

Standard Deviation	$279.08
Number of Providers > +/-1SD	2
Mean(Average)	$389.60
Sample Size	31
Lower Limit (95% CI)	$287.23
Upper Limit (95% CI)	$491.96

Chapter 6
Process & Procedures

CTDHP Prior Authorization Requirements

As of February 1, 2010, prior authorization (PA) is required for select services based on patient 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 subject 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, detailed information should be included. 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.

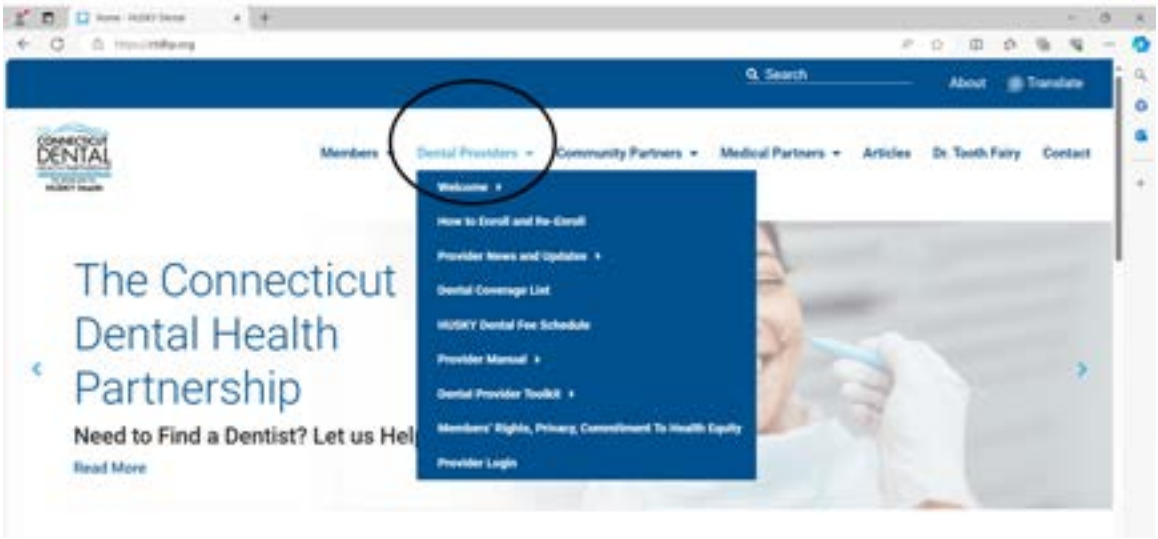
The ADA form and all required supporting documentation must be sent to CTDHP/BeneCare at the following address:

CT Medicaid Prior Authorizations
C/O Benecare
555 City Ave. Suite 600
Bala Cynwyd, PA 19004

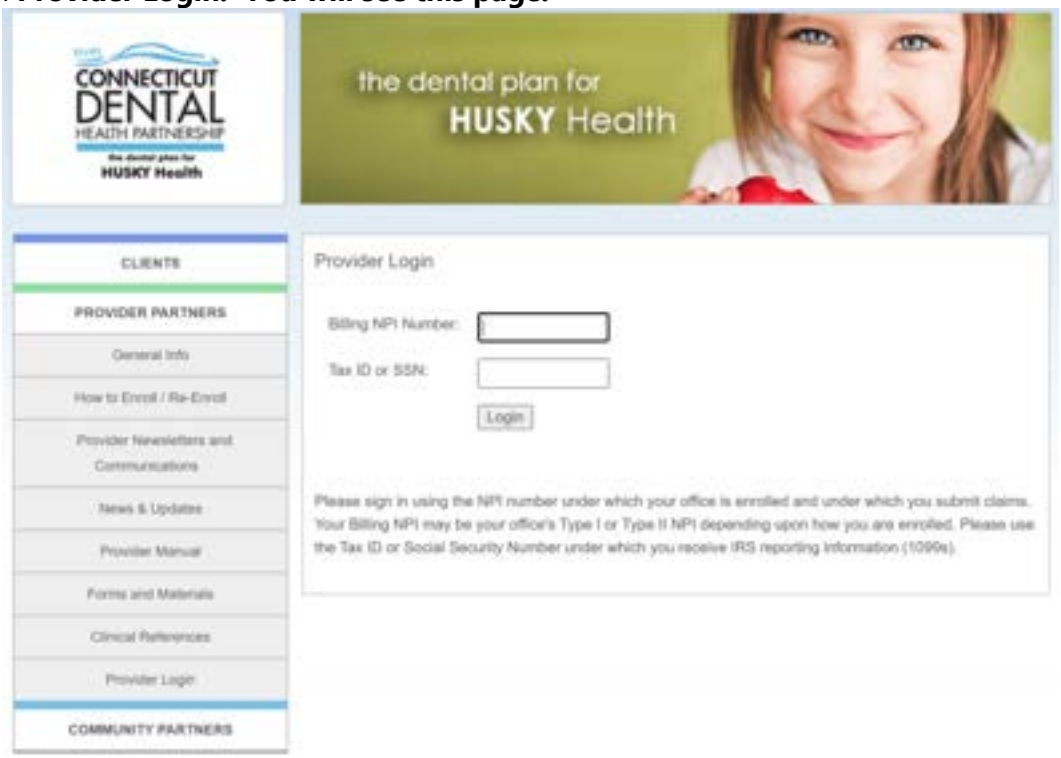
Submissions lacking required documentation will be pended and a request for the missing documentation will be mailed to the submitting dentist. All radiographs will be returned. Digital radiographs supplied in the paper format will be returned if labeled "Return to Provider."

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:

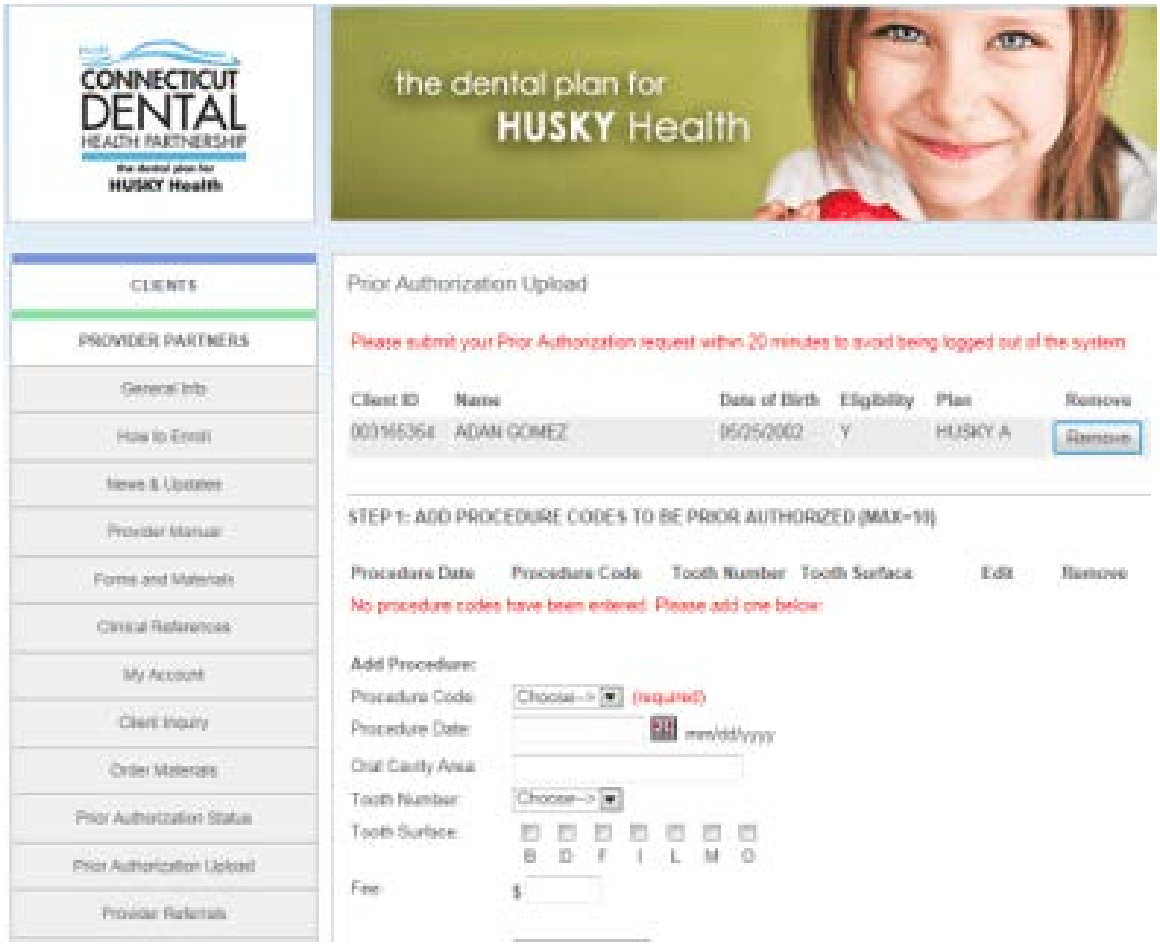
Access CTDHP at www.ctdhp.org.
Click on **Dental Providers https://ctdhp.org/**



Click on **Provider Login. You will see this page:**

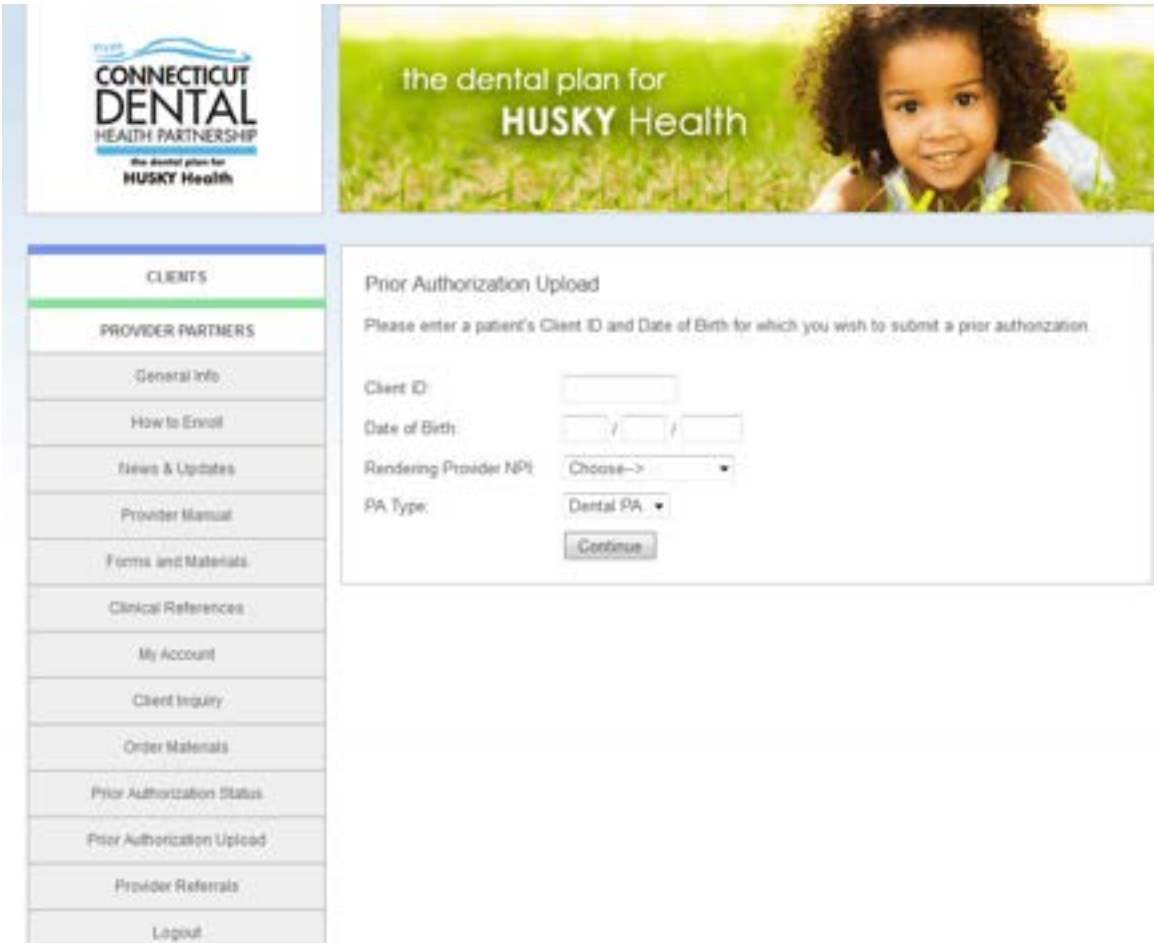


Enter your Billing NPI and Tax ID numbers. Click **Login**.



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 or Perio PA upload instruction continue to section titled **Ortho PA Upload or Perio PA Upload**.

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



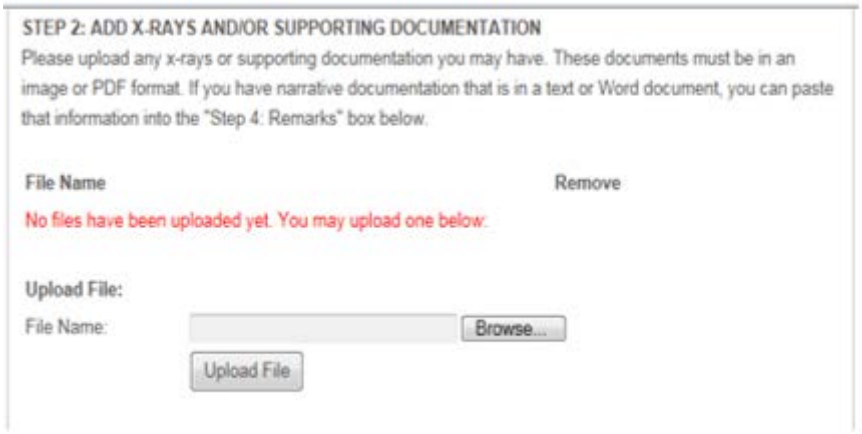
Step 1: Add Procedure.

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.

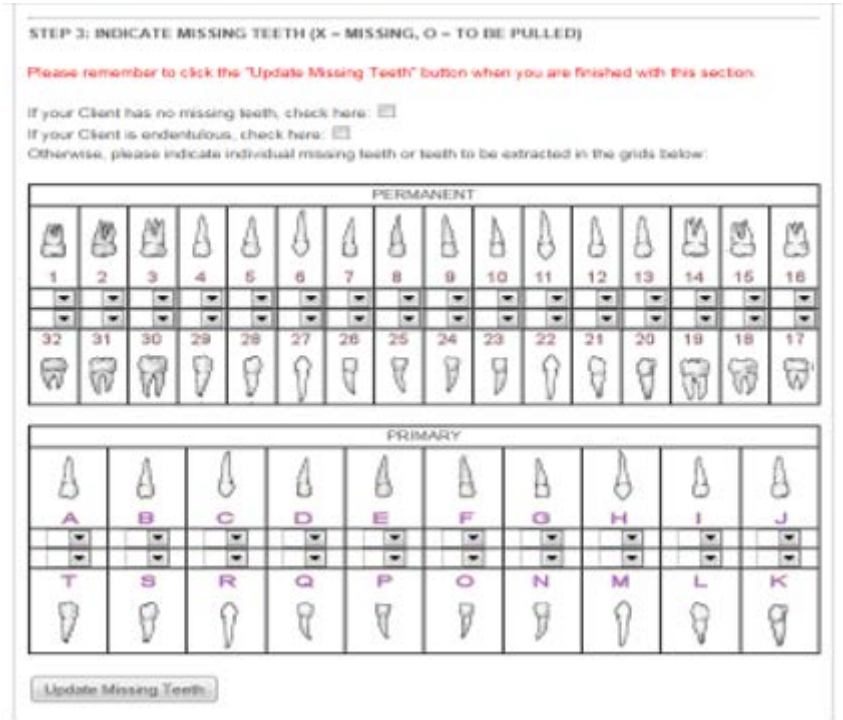
Step 2: Add X-rays and/or Supporting Documentation

- 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.



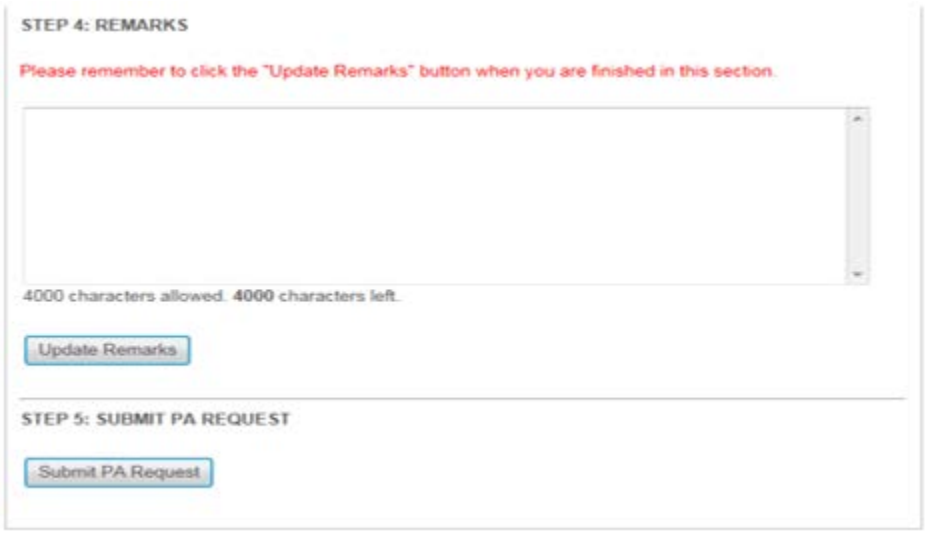
Step 3: Indicate Missing Teeth and Teeth to be Extracted

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.

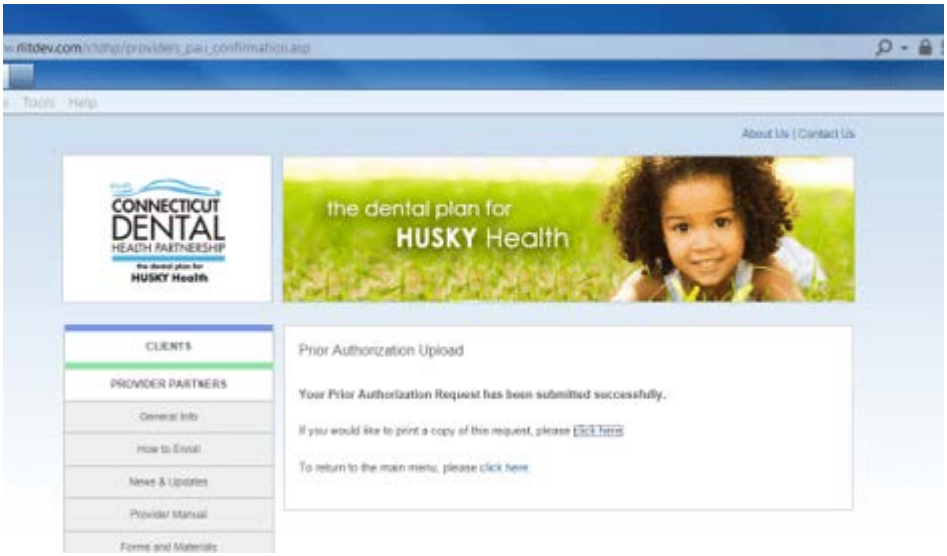


Remarks

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.

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**.

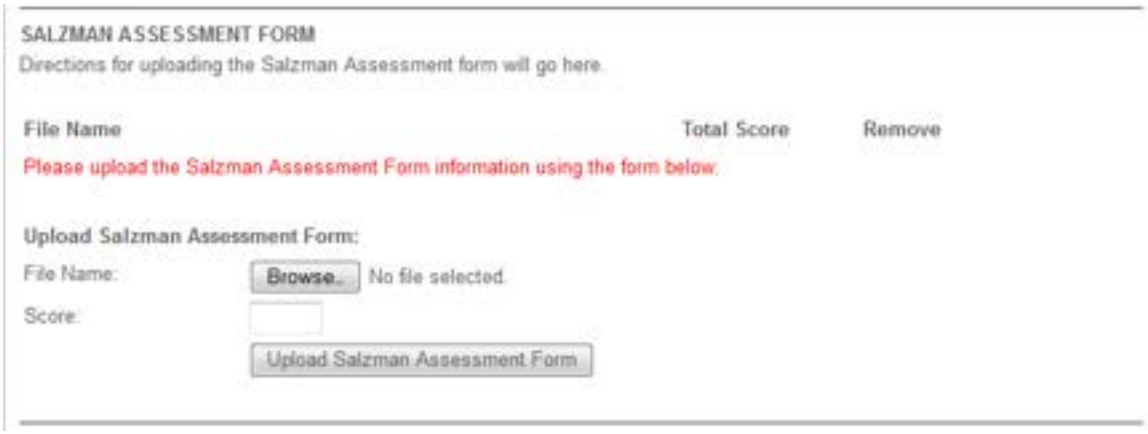
Step 1: Add Procedure.

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.

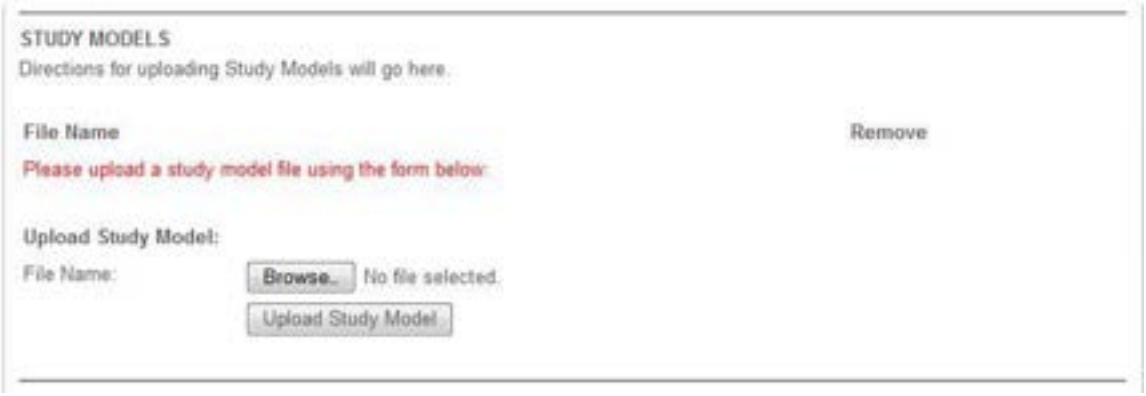
Step 2: Upload Salzmann Assessment Form

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



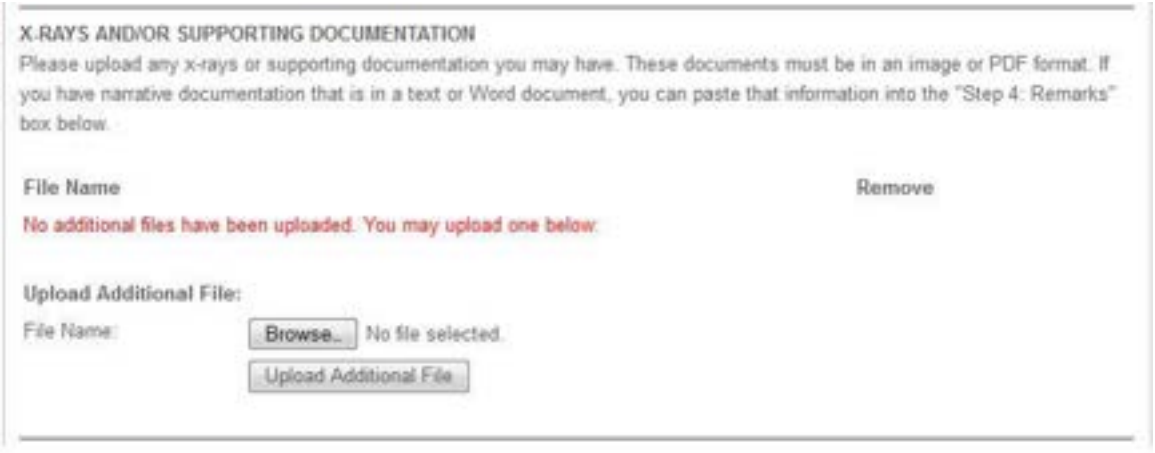
Step 3: Upload Study Model

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



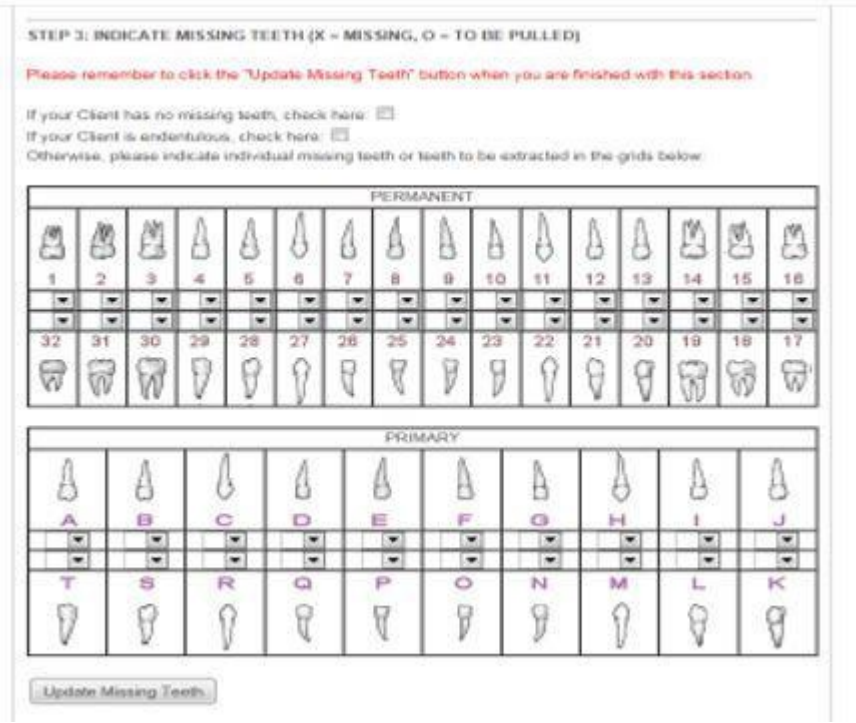
Step 4: Upload X-rays and/or Supporting Documentation

- 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.



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 6: Update Remarks and Submit

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 see 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 twenty-one (21) business days for the review and processing of prior authorization and post procedure review requests. You should schedule patients at least four (4) weeks out from the date of submission.

Approved prior authorizations/post procedure reviews will be sent to Gainwell 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 Gainwell 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 Gainwell electronically via the Gainwell Web Portal. A sample PA authorization form follows:

Prepared: 2/12/2024

Claim No: **Plan Sponsor:**
ID Number: **Primary Member:**

Dear

This notice serves as the status of a request for prior authorization (PA) of the listed dental services for the Connecticut Dental Health Partnership member 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 prior to each member appointment to ensure eligibility has not changed.

Please return this letter with any additional documentation requested. Claim forms for payment of approved and completed services should be sent to Gainwell Technologies, or submitted via the web portal or your claims submission software.

If you have any questions, please contact us directly at 888-445-6665.

Thank you.

Connecticut Dental Health Partnership
BeneCare Dental Plans

****SEE DETAILS ON REVERSE SIDE**

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 Gainwell 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 by logging into our website: www.ctdhp.org or via the Gainwell Web Portal. Your office must have signed up with Gainwell in order to access this secure site. All dental providers can log on to their secure Gainwell 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 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**.

Emergency Prior Authorization Requests

In the event an "emergency "prior authorization is needed, contact CTDHP Provider Service Representatives at 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.

Prior Authorization Frequently Asked Questions

Which dental services require prior authorization?

Please refer to the dental fee schedule posted on the Connecticut Medical Assistance Program Website: 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.
- Periodontal Services

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.

What documentation is required in order to obtain prior authorization?

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.

Is prior authorization the same as pre-determination?

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 members 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.

Once a request for prior authorization is approved, how are claims for payment handled?

All payments for Connecticut Medical Assistance Program dental claims will continue to be made by Gainwell 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 Gainwell via electronic, web portal or paper format.

How long are prior authorizations valid?

Prior authorizations (PAs) for prospectively reviewed services will be valid for 365 days from the date of issue. Post procedure authorizations (PRs) 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.

Where do I send my request for prior authorization or post procedure authorization?

Prior Authorization requests **should not** be sent to Gainwell 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
555 City Ave. Suite 600
Bala Cynwyd, PA 19004

Can I appeal denials of prior authorization or post procedure authorization requests?

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).

Can prior authorization be requested for services that are not on the DSS fee schedule?

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.

Can prior authorization be requested for services outside of the program limitations in the DSS Medical Services Policy for dental services?

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.

Are additional cleanings and exams approved for adults?

If medically necessary. Certain medical conditions allow for more than one cleaning per year for adults. Refer to the Dental-Medical Integration flyer on the website: https://ctdhp.org/dental-providers/dental-provider-toolkit/ for more details.

If a client requests services that are not Medicaid covered services, is prior authorization required?

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.

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?

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.

What is the expected turnaround time for a decision given a complete prior authorization submission?

On average, approval and/or denial status notices will be issued within twenty-one (21) 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.

How do I know if we are using the correct specialty and taxonomy designators in our claims submissions?

If you have any questions about the specialty and taxonomy designators under which you have been enrolled by Gainwell and which designators to use on your claim forms, please contact Gainwell at 800-842-8440.

How does the provider taxonomy chart in Chapter 2 apply to my practice?

The chart is there to demonstrate how Gainwell has moved from three limited dental specialties to encompass all current dental specialties.

How do I know what the program guidelines are?

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.

Will a service that is prior authorized be specific for the patient or provider or both?

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 Gainwell. 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.

Is there a mechanism to obtain prior authorization over the phone?

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.

If the client selects another dentist after prior authorization was obtained, is a new authorization required?

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 calling CTDHP's PA department at (888) 445-6665.

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?

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

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?

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 CTDHP programs, all requests will be handled as primary carrier claims.

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?

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.

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?

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

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?

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.

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?

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.

What is the correct way to discuss and bill for a procedure where the client requests an upgrade?

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.

What if Medicaid covers a cast crown for a posterior tooth but the client wants a porcelain fused to metal crown?

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?
    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, 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?
    a. Yes, proceed to #4
    b. No, endodontic therapy would not meet coverage guidelines. Recommend alternative treatment modality

4. Does the client have intact dentition (other than third molars or bicuspids extracted for orthodontic therapy) in the quadrant of the tooth to be treated?
    a. Yes, proceed to #9
    b. No, proceed to #6

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, proceed to #7

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, client appears to qualify for bilateral partial denture, proceed to #9
        ii. No, proceed to #8
    b. No, proceed to #7

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, endodontic therapy would not meet coverage guidelines. Recommend alternative treatment modality in order to completely restore the arch

b. 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?
    a. Yes, proceed to #9
    b. 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 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 bicuspids 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?
            - Yes, client appears to qualify for a single crown. Proceed to #9
            - 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).**

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.

10. Is the client currently eligible for dental services under Medicaid?
    a. Yes, proceed to #2
    b. No, services cannot be reviewed or covered

11. 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

12. 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

13. Does the client have intact dentition (other than third molars or bicuspids extracted for orthodontic therapy) in the quadrant of the tooth to be treated?
    a. Yes, proceed to #9
    b. No, proceed to #5

14. 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

15. 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?

- Yes, client appears to qualify for a single crown. Proceed to #9
- 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

16. 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

17. 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

18. 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

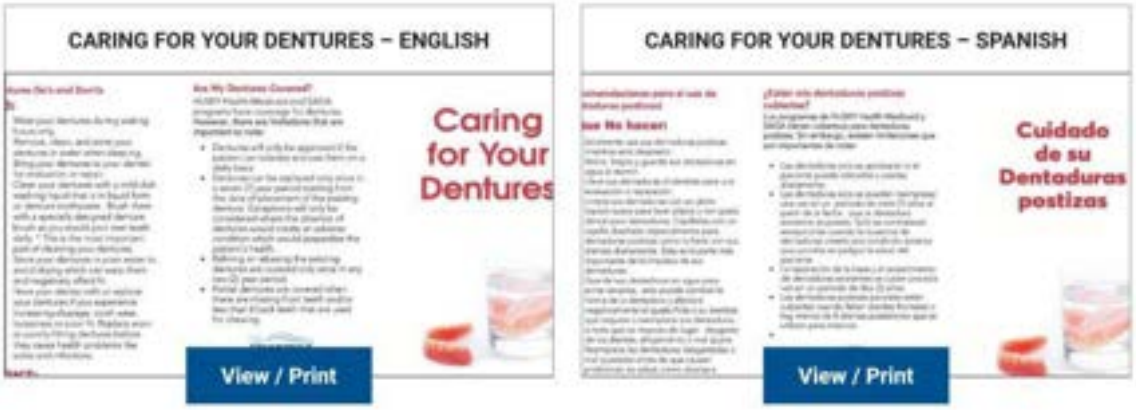
5. Do the abutment teeth in the arch being considered for the partial denture in question each have a favorable prognosis free of periodontal involvement and free from root fracture(s) and sufficient crown structure remains to support the prosthesis?
    a. Yes, proceed to #6
    b. No, address existing 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

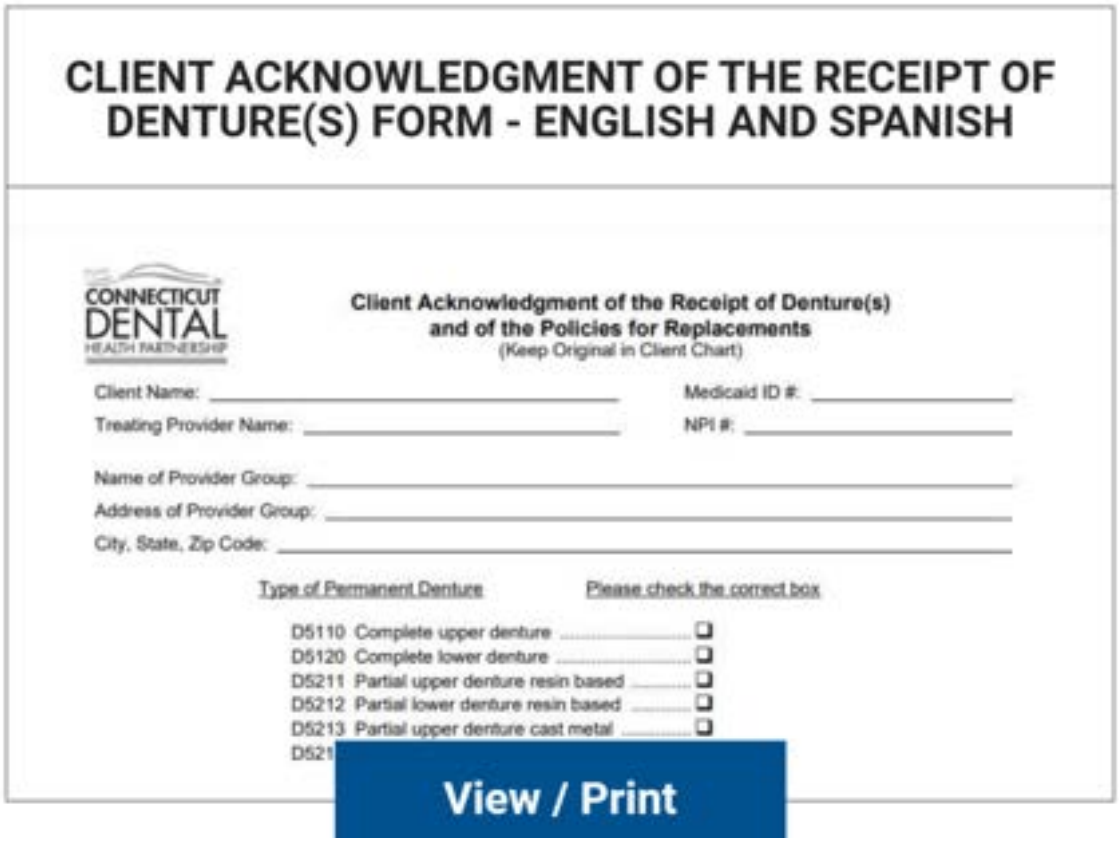
7. Submit prior authorization request including mounted preoperative periapical x-rays of the remaining dentition, PAN or FMX (No bitewing x-rays will be accepted), and complete charting of the client's dentition (including any planned extractions)

Denture Benefit

Full or partial dentures are a covered service which requires prior authorization. The CTDHP brochure, *"Caring for Your Dentures,"* covers basic information for your patients regarding the attention they will need to give their new dentures. It is available in English and Spanish and can be downloaded from here: https://ctdhp.org/resources/. 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, please have your client read and initial / sign a ***"Client Acknowledgement of Receipt of Denture(s) and a Description of the Policies for Replacements"*** form, also downloadable from: https://ctdhp.org/resources/.



When you deliver denture(s) to CTDHP / HUSKY Health members, please have them read and initial/sign the form. Keep the original signed copy of the form in the client's chart.

Brochures and acknowledgement forms were sent to each enrolled dental office which has provided dentures. Additional supplies of these documents can downloaded at the CTDHP website (https://ctdhp.org/) 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 upon 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
555 City Ave, Suite 600
Bala Cynwyd, PA 19004

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:

Acronym Element	Description
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:

1. ***Assurance*** of the availability and accessibility of required health care resources; and
2. ***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 clients as healthy as possible;
- Improve the clients' health;
- Identify or treat illnesses or conditions, 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:

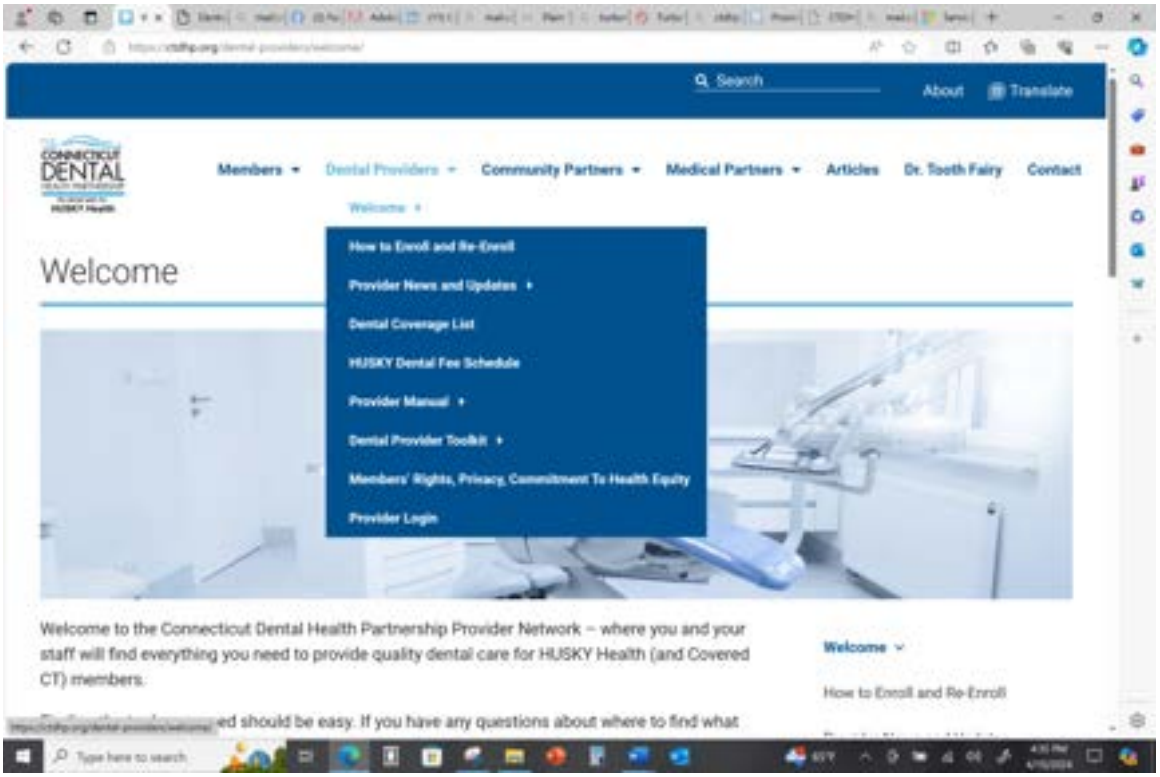
1. Fill out the standard PA claim form. Be sure to check off the correct box contained in question 1 which states "EPSDT/Title XIX
2. Fill out the PA claim form including all of the necessary information, including your usual and customary charge for the actual ADA CDT procedure codes requested
3. Include 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
   555 City Ave. Suite 600
   Bala Cynwyd, PA 19004
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

Dental Coverage Limitations By Program		
Procedure Service	**Common ADA Codes**	**Program Coverage**
Periodic Oral Exam	D0120	For clients <21 years of age-Limited to one per client per 6 month period. For clients 21 years of age or older-Limit to one per client per 12 month period. **Effective September 1, 2014, D0120 is no longer payable for the following specialties: Endodontists, Oral & Maxillofacial Radiologists, Oral & Maxillofacial Pathologists, Anesthesiologists, Oral Surgeons, Orthodontists, and Hygienists** **Note:** 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. **-No HUSKY B Copay** **- Source: Provider Bulletin 2011-61, 2014-62 & Chapter 7 of the CT DSS Dental Provider Manual**
Emergency or Limited Oral Exam	D0140	Effective September 1, 2014, both children and adults are eligible for only four (4) problem focused exams per calendar year **-No HUSKY B Copay** **-Source: Provider Bulletin 2014-62 and Chapter 7 of the CT DSS**

SAMPLE DENTAL BENEFITS LIMITATIONS / COVERAGE LIST

For the Most Up to Date Dental Coverage List, visit here



Orthodontic Services: Regulations and Procedures

Orthodontic Case Review Standards and Guidelines

With the exception of HUSKY B members, 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 26 or more points on a correctly scored Malocclusion Severity Assessment.

  Or…

- The client is an Eligible HUSKY Health member, who scores below 26 but has been in continuous therapy for six months or more with a physician, licensed psychologist, licensed clinical social worker, independent licensed practitioner, family counselor, or another recognized and licensed specialist who attests that orthodontic treatment will significantly ameliorate the psychological condition or conditions caused by the malocclusion.

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 – also viewable on the CTDHP website with the WELCOME tab.

Connecticut Dental Health Partnership

Children's Oral Health Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Periodicity Schedule

The Connecticut Department of Social Services HUSKY Health dental program, known as the Connecticut Dental Health Partnership, follows the American Academy of Pediatric Dentistry's guidelines for periodicity of examination and preventive dental services, anticipatory guidance and treatment for infants, children, teenagers and young adults up to the age of twenty-one. Continuity of care is based upon each child's unique needs and should be performed at an established dental home. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal.

	6 - 12 Months	12 - 24 Months	2 - 6 Years	6 - 12 Years	12 - <21 Years
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and Topical Fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [3]	•	•	•	•	•
Anticipatory guidance / counseling [6]	•	•	•	•	•
Oral Hygiene Counseling [5,7]	Parent	Parent	Patient / Parent	Patient / Parent	Patient
Dietary Counseling [12]	•	•	•	•	•
Counseling for nonnutritive oral habits [9]	•	•	•	•	•
Injury prevention and safety counseling [10]	•	•	•	•	•
Assess speech / language development [11]	•	•	•		
Assessment developing occlusion [11]			•	•	•
Assessment for pit and fissure sealants [13]			•	•	•
Periodontal risk assessment [3, 14]			•	•	•
Counseling for tobacco, vaping and substance misuse				•	•
Counseling for human papilloma virus / vaccine				•	•
Provide counseling on intraoral piercings				•	•
Assess third molars					•
Transition to adult dental care					•

Se footnotes below.

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status / susceptability to disease. Includes assessment of pathology and injuries.
2. By clinical examination.
3. Must be repeated regularly and frequently to maximize effectiveness.
4. Timing, types and frequency determined by child's history, clinical findings, and susceptability to oral disease.
5. Consider when systematic fluoride exposure is suboptimal. Up to at least 16 years.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially, responsibility of parent, as child matures, jointly with the parent, then, when indicated, only child
8. At every appointment, initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity. Monitor body mass index beginning at age 2.
9. At first, discuss the need for nonnutritive sucking; digits vs. pacifiers; then the need to wean from the habit malloclusion or deleterious effect on the dentofacial complex occurs. For school aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching or bruxism.
10. Initially, pacifiers, car seats, play objects, electric cords, secondhand smoke, when learning to walk, with sports and routine playing, including the importance of mouthguards, then motor vehicles and high-speed activities.
11. Observation for age appropriate speech articulation and fluency as well as achieving receptive and expressive language milestones.
12. Identify, transverse, vertical and sagittal growth patterns; asymmetry; occusal disharmonies; functional status including temporomandibular joint dysfuntion (TMD), esthetic influences on self-image and emotional development
13. For caries susceptible primary molars, permanent molars, premolars and anterior teeth with deep pits and fissures, placed as soon as possible after eruption.
14. Periodontal probing should be added to the risk assessment process after the eruption of the first permanent molars.

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 members, 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 Gainwell, 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 $3,210.00 and will be comprised of the following:

- One (1) initial payment for Comprehensive Orthodontic Treatment (D8080) of $584.31
- Thirty (30) monthly payments for Periodic Orthodontic Treatment Visits (D8670) of $87.13

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) – $85.00
- Diagnostic Casts (D0470) – $96.00
- Pre-orthodontic Visit (D8660) – $33.00

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 $3,424.00.

Please note you must be an actively enrolled provider with the Department, through Gainwell before BeneCare can approve or transmit your approved orthodontic case claim for payment. If you are not currently enrolled with the Department through Gainwell or have questions about your enrollment status, please contact our Senior Director of Professional Relations, 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 Gainwell on your behalf.

Orthodontic Case Submissions

Cases may be submitted electronically at https://ctdhp.org/ (see earlier in this chapter 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:
    - Client's name as it appears on their grey CONNECT card
    - Client's Medicaid ID number as it appears on the CONNECT card
    - Dentist's name and name of facility if applicable
    - NPI, TIN and SSN identifiers as appropriate
    - Standard ADA CDT procedure code(s)
    - Description of procedure in English
    - Doctor's usual and customary fee(s)
    - 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:

CONNECTICUT DENTAL HEALTH PARTNERSHIP
the dental plan for HUSKY Health

Member: ID#:

Claim #: Date:

Dear Doctor:

Your request for review of orthodontic services for your patient is incomplete as submitted or, 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 gray CONNECT card is required
- ☐ Client's Medicaid ID number as it appears on their gray 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
- ☐ Dentist's usual and customary fee(s) 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
- ☐ Resubmit when dentition matures
- ☐ Based on your clinical review, this case does not meet the criteria of the Connecticut Medical Assistance Program. Coverage of braces to treat crooked teeth is based on a scoring method. If the score is 26 points or above, braces are covered. If the score is below 26 points, braces may be considered medically necessary if (a) there is difficulty chewing or swallowing food or there is a severe problem affecting the mouth which, if left untreated, would cause irreversible damage; or (b) a licensed child psychologist or psychiatrist has done an evaluation and concluded that the child has specifically defined severe emotional and/or behavior problems that are the result of the condition of the teeth, which will greatly improve if the child gets braces.
- ☐ Interceptive treatment is not a Medicaid covered service: patient has mixed dentition and no documentation from referring general dentists, behavior health or mental health providers, or other severe deviations affecting the 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.
- ☐ Other_____

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 OPEN	SPACING CLOSED	NO.	POINT VALUE	SCORE
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	
Ant = anterior teeth (4 incisors). Post = posterior teeth (including canine, premolars, and first molar). No. = number of teeth affected.							TOTAL SCORE		

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	7 8 9 10		X 2	
*Score maxillary or mandibular incisors. No. = number of teeth affected.					TOTAL SCORE		

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	
1st Premolar										X 1	
2nd Premolar										X 1	
1st 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

Frequently Asked Questions on Orthodontic Cases

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.

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 Salzmann 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.

When scoring the Salzmann Scoring Sheet, can a tooth be considered crowded and rotated?

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

Are electronic models acceptable?

Yes. At this time, we currently accept digital study models produced using emodels, Ortho Select and Ortho Cad.

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.

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.

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.

Who pays if the patient scores less than a 26 on the Salzmann index?

If a patient scores less than 2 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.

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.

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.

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.

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.

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.

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.

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.

What can an office do if a client speaks a foreign language and the office does not have someone who can translate?

The office has the option of obtaining a translator, but it is the office's responsibility to pay the expense.

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.

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.

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 Benefits

For the most current benefits for Adults, refer to the ctdhp.org website. This listing can be found under the MEMBERS Tab – Your Benefits:

https://ctdhp.org/your-benefits/

Codes for these services are found under the PROVIDERS Tab – Dental Coverage List

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 website or via hard copy to:

CT Medicaid Prior-Authorizations
Connecticut Dental Health Partnership
C/O BeneCare Dental Plans
555 City Ave.
Bala Cynwyd, PA 19004

Adult Benefits - Questions and Answers

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

1. 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.
2. Adults with certain medical conditions may be eligible for a second cleaning without preauthorization. **Refer to the Dental Provider Toolkit on ctdhp.org for the most current list of approved conditions:** https://ctdhp.org/dental-providers/dental-provider-toolkit/

As of 1/15/22, these conditions are:

- Alzheimer's Disease
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease
- Diabetes Type 1
- Diabetes Type 2
- Disease of the Intestine
- Unspecified Diseases of oral cavity and salivary glands
- Ear Nose and Throat Cancers
- End Stage Renal Disease
- Hemophilia
- HIV/AIDS
- Hypertension
- Kidney Disease
- Liver Disease
- Lung Cancer
- Lupus
- Osteoporosis
- Pancreatic Cancer
- Sickle Cell Disease

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.

While the Medicaid Program allows for a certain benefit package, the provider is responsible for providing 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.

What about adult developmentally disabled patients? They need to be seen every 3 months?

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. Documentation must be included on line 35 of the PA form describing the client's condition.

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?

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.

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

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 of the Medicaid Program (pro bono) they may do so.

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?

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.

Can an office charge a patient for a higher end denture?

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.

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?

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.

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.

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

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.

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

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
555 City Ave.
Bala Cynwyd, PA 19004

Dental Anesthesia Coverage Guidelines and Prior Authorization Requirements

See the Dental Coverage List on ctdhp.org for the most current guidelines.

ADA Procedure Code	Description	Benefit Limitations	Coverage Criteria
D9220* D9221*	Deep Sedation/ General Anesthesia First 30 minutes Deep Sedation/ Add'l 15 minutes	Covered for clients under the age of nine (prior to 9th birthday) or clients that have a demonstrated cognitive impairment/need such as autism, cerebral palsy, hyperactivity disorder or severe/profound develop-mental delay for behavior management related to the dental procedures being performed.	Covered for clients age 9 to 20 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

CONNECTICUT DENTAL HEALTH PARTNERSHIP
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

Administered by BeneCare

Claim Submission and Payment Requirements

Claims from enrolled providers are processed by Gainwell, through the Gainwell secure web portal or they may be sent electronically.

Electronic submitters should refer to the Gainwell website at www.ctdssmap.com. Dental providers may also use the web portal claim submission feature. For additional information on electronic claim submission, please contact Gainwell at 800-842-8440.

Providers have one year from the date of service to submit claims for payment.

Remittance Advice

All claims received by Gainwell 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 Gainwell.

Patient Record Requirements

Providers are responsible to maintain a unique record for each client eligible for Connecticut Medical Assistance Program payment. The record should include, but not limited to:

- Name
- Address
- Phone number
- Birth date
- Email address (if available)
- Connecticut Medical Assistance Program identification number
- Pertinent diagnostic information
- X-rays
- Current and all prior treatment plans
- Pertinent treatment notes signed by the provider
- Documentation of the dates of service

And, other requirements as provided by federal and state statutes and regulations pursuant to 42 CFR482.61 and, to the extent such requirements apply to a provider's licensure category, record requirements set forth in chapter IV of the Connecticut public health code (sections 19-13-d1 to 19-13-d105 of the regulations of Connecticut State Agencies).

These records and information shall be made available to representatives of the Connecticut Dental Health Partnership upon request.

Chapter 7
Member Care and Community Connections and Additional Supports (*formerly Care Coordination and Outreach*)

CTDHP Member Care and Community Connection Overview

One of the components that make the Connecticut Dental Health Partnership (CTDHP) unique is its state-wide Member Care and Community Connections Team. HUSKY Health and Covered CT member care and community connections efforts focus on two distinct areas:

1. Oral Health Navigation: Oral Health Navigators develop a collaborative process between the member and Dental Provider(s) to assess, plan, remove/reduce barriers and meaningfully link members to meet their acute oral healthcare needs and support the member in establishing routine and preventative oral health behaviors and services.
2. Community Engagement: Community Engagement Specialists develop, design, implement, and monitor community-based communications and activities to increase awareness of the HUSKY Health dental plan benefits, promote contact information (phone and website), provide a broader understanding of the services provided by the CT Dental Health Partnership, and distribute oral health related information and education to members, community partners, provider populations and oral health advocates.

Oral Health Navigation

Oral Health Navigation (*formerly referred to as Care Coordination*) is a collaborative process between the member, Oral Health Navigator, and Dental Provider(s) to assess, plan, remove/reduce complex barriers to care and meaningfully link members to meet their acute oral healthcare needs and support members in establishing routine and preventative oral health behaviors and services.

Complex barriers to care are typically defined as members whose medical, behavioral, and/or social needs are impacting accessing and completing oral health treatment. Acute oral health needs are determined by both the member and the dental provider, evidenced by the member's own experience, the dental treatment plan developed by the dental provider, and the HUSKY Dental Plan Benefit that determines payment for care.

Oral Health Navigation is longitudinal in nature and focused on marshalling the resources, education, and interventions to support members in meeting their oral health goals.

Oral Health Navigation Goals

- To ensure member's acute oral health needs are met by dental providers.
- To assist in removing or reducing the member barriers to accessing oral health services and completing the dental treatment plan determined by the dental provider.
- To provide resources and education to empower members to achieve good oral health practices.
- To support the member in establishing routine preventative oral health services.

Philosophy of Person-Centered Care Coordination and Services

Oral Health Navigation is provided to members and is rooted in a philosophy of person-centered care. Adapted from the World Health Organization person centered care is: "[an] approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centered care requires that people have the education and support they need to make decisions and participate in their own care."

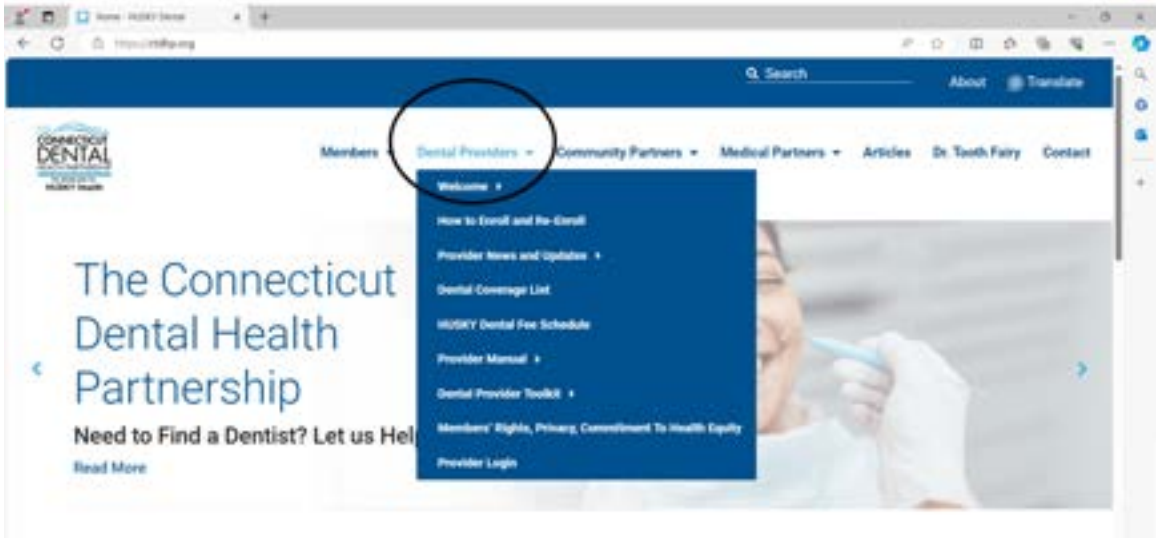
In some cases you may receive assistance from our teams or Oral Health Navigators who can assist HUSKY Health and Covered CT members in coordinating their care. Referral is through the Member Services Call Center at 855-CT-DENTAL, through the Member **Referral portal on ctdhp.org, or via the Unite Us referral tool**. Oral Health Navigators assist Members who face significant barriers to accessing care. They will work with you, the Member and other providers to ensure that the Member gets the dental care that they need.

Community Engagement

Community Engagement Specialists (*formerly known as Outreach – Dental Health Care Specialists*) develop, design, implement, and monitor community-based communications and activities to increase awareness of the HUSKY Health dental plan benefits, promote contact information (phone and website), provide a broader understanding of the services provided by the CT Dental Health Partnership, and distribute oral health related information and education to members, community partners, provider populations and oral health advocates. Currently, CTDHP's Community Engagement Specialists cover 4 regions in the state.

Enhanced CTDHP Website – CTDHP.COM is now CTDHP.ORG

The new CTDHP website offers a myriad of information for dental professionals on a user-friendly, mobile-friendly platform.



Welcome

The Welcome Tab – gives you easy access to:

- Provider News and Updates;
- your Provider Login Page;
- the Dental Fee Schedule;
- the Dental Benefits Coverage List;
- the EPSDT Schedule;
- and the Gainwell phone number.

How to Enroll and Re-enroll

The How to Enroll and Re-enroll tab gives step by step instructions for enrolling in the HUSKY Health and Covered CT program as a participating provider.

Provider News and Updates

This tab provides yet another way of accessing Provider News and Updates that include Policy Updates and an Archive of all updates. The link also provides access to the most current and archive of Provider newsletters. It also offers a link to our Connecticut "Oral Health Heroes," providers who have been noted for going above and beyond over the years. You can also access this information directly from the ctdhp.org home page, or welcome page.

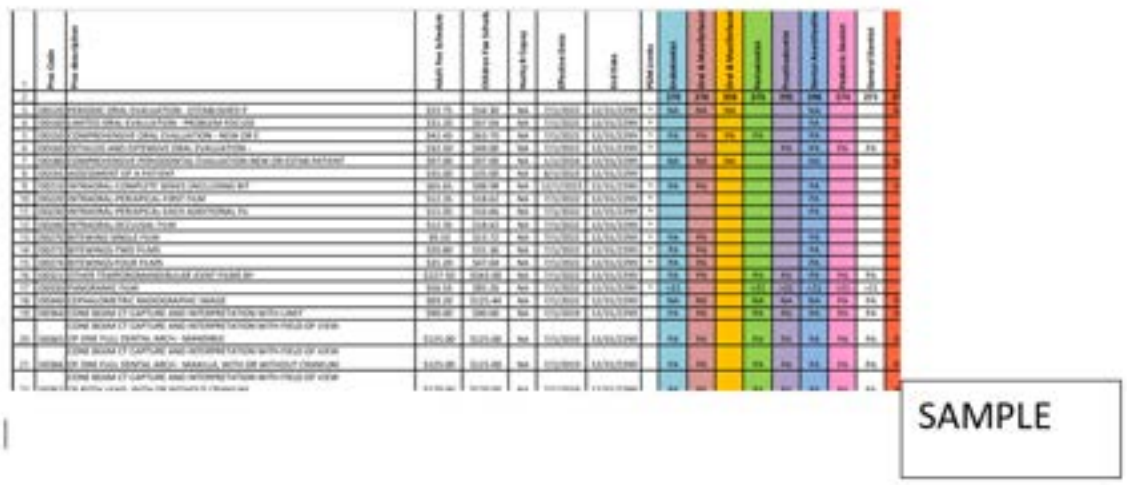
Dental Coverage List

This tab provides access to the most up-to-date grid of dental benefits. This listing of dental limitations by program notes:

- Procedure Services
- Common ADA Codes
- And, any service information, source documents and limitations for HUSKY A HUSKY B (Eligible to age 19) HUSKY C & HUSKY D

HUSKY Dental Fee Schedule

This tab will lead you to the most up-to-date Dental Fee Schedule. This is a very colorful, printable document that includes: procedure codes and descriptions; fees for adults and children; copays, effective dates, end dates, PGM Limits and Specialist PA requirements.



Provider Manual

This section will be offered in a chapter by chapter and complete, printable document format and should be, for the most part, searchable using the website search tool.

Dental Provider Toolkit

This toolkit should contain all the tools you need for successful program implantation. It includes more easy links to:

- The Dental Coverage List
- For Adult Patients – the list of Medical Conditions that Qualify for Two Cleanings a Year
- The Dental Fee Schedule

It also provides access to three key sections:

1. Forms and Compliance Documents
2. Provider Reference Materials
3. **A link to Medical / Dental Integration and the ABC Program**

1. Forms and Compliance
Included in this section:

- Treatment Plan Template – Example
- Periodontal Treatment Pledge and Action Plan (Also available in Spanish, French, and Portuguese).
- Informed Consent for Payment – Sample Client Acknowledgment of the Receipt of Dentures
- Third Party Liability (TPL Information (How to Update)
- Annual Provider Surveyv

Secure Access to Dental Plan Related Patient Information

- Letter To HUSKY Health Dental Provider Language Assistance Services For Individuals With Limited English Proficiency
- Compliance Required – Connecticut Dentists
- Notice Of Non Discrimination (15 Employees Or Less), Notice Of Non-Discrimination (More Than 15 Employees)

2. Provider Reference Materials

Included in this section are downloadable references in the following areas:

- Dentures
- Anesthesia
- Orthodontics
- Early Childhood and EPSDT
- Perinatal
- Periodonatal Services
- Oral Cancer and Tobacco Cessation
- Special Health Needs
- Abuse and Neglect
- CTDHP Logos

3. A Link to Medical / Dental Integration and the ABC Program

The link to the Medical / Dental Integration and ABC pages.

Member Rights, Privacy, and our Commitment to Health Equity

This tab links to the same information that is provided in the Member section of the website. It provides an outline of Member Rights and Responsibilities, Privacy Rights and important information to ensure oral health equity for HUSKY Health and Covered CT Members.

Provider Login

The last tab, is the one you may use the most. This is the access to our secure portal that still resides on the ctdhp.com platform. It has been kept their for extra security of HIPAA information and the information you will need for:

- Verifying Eligibility
- Uploading Prior Authorizations
- Verifying Prior Authorization Status
- Viewing Patient Treatment History

Making Referrals

Dental offices, other medical providers, community agencies and clients can call our toll-free client services line to make a referral for the above services:

855-CT-DENTAL

Monday to Friday • 8:00 AM to 5:00 PM

Excluding major holidays • Answering service available off-hours

Chapter 8 Policy and Bulletins Listing

How to Download Bulletins and Policy Transmittals

From time to time, provider bulletins and policy transmittals are published. To view and/or print these publications, go to https://www.ctdssmap.com/CTPortal/Information/Publications/tabid/40/Default.aspx

Or, refer to the listing below:

The following bulletins are recommended reading for all Dental Providers:

Date	Bulletin Number	Title
2024	PB2024-30	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule
2024	PB2024-12	Changes to the Dental Fee Schedule
2024	PB2024-08	Clarifying Billing Guidance for Periodontal Services
2023	PB2023-79	January 2024 Quarterly HIPAA Compliant Updates- Dental Fee Schedules for Adult
2023	PB2023-69	UPDATED: Addition of Periodontal Benefits
2023	PB2023-68	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule
2023	PB2023-57	Adding Select Procedure Codes for Evaluation/Management Services to Dental Fee Schedule
2023	PB2023-54	Multi-disciplinary Examinations for Medical, Behavioral Health and Dental Service
2023	PB2023-41	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule
2023	PB2023-12	Changes to the Dental Fee Schedule
2022	PB2022-101	January 2023 Dental HIPAA Compliant Update
2022	PB2022-90	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule
2022	PB2022-64	Dental Claim Form Field Update Reminder
2022	PB2022-56	Covered CT Program
2022	PB2022-55	Dental Fee Schedule Update for the Adult Fee Schedule
2022	PB2022-43	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule
2022	PB2022-33	Extension of Postpartum Care
2021	PB2021-100	Revised January 2022 Quarterly Dental Fee Schedule HIPAA Compliant Update
2021	PB2021-94	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule
2021	PB2021-61	Treatment Planning and Radiographic Imaging Requirements
2021	PB2021-60	Oral Health Assessment and Fluoride Varnish Applications Services at Well Child Visits
2021	PB2021-52	Reminder for Medical Necessity for Dental Imaging and Limitations for Occlusal

Date	Bulletin Number	Title
2021	PB2021-51	Dental Digital Models
2021	PB2021-36	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule
2020	PB2020-82	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule
2020	PB2020-51	Electronic Claims Submission, Web Remittance Advice, Check, EFT and 835 Schedule
2020	PB2020-11	Accessing the Provider's Re-enrollment Due Date
2019	PB2019-87	2020 Dental Fee Schedule Clarifications and HIPAA Compliance Update
2019	PB2019-66	Update to Dental Fee Schedule for Composite Restorations of Incipient Carious Lesions
2019	PB2019-47	Updated Prior Authorization Requirements for Frenulectomies for Children
2019	PB2019-42	Update for Adult Dental Fee Schedule for Composite Restorations on Molar Teeth
2019	PB2019-41	Update to Dental Fee Schedule for Cone Beam Computed Tomography Imaging
2019	PB2019-38	Update for Billing Coding for Access to Baby Care (ABC Program)
2019	PB2019-24	Annual Dental Benefit Maximum
2019	PB2019-03	2019 Dental Fee Schedule Clarifications and HIPAA Compliance Update
2018	PB2018-51	2018 Dental Fee schedule Update for CDT D1354
2018	PB2018-47	PA Requests for D7997 and D86922018
2017	PB2017-95	2018 Dental Fee Schedule HIPAA Compliance Update
2017	PB2017-81	Dental Benefit Annual Maximum Limitation
2017	PB2017-54	Reasons of Medical Necessity for Dental Periapical Imaging
2017	PB2017-41	Addition of CPT Code 41899
2017	PB2017-29	Provider Audit Trainings
2017	PB2017-09	2017 Dental Fee Schedule HIPAA Compliance Update
2016	PB2016-96	Elimination of Paper Claims Update
2016	PB2016-90	Interpreter Services for Individuals with limited English
2016	PB2016-75	Changes to Implementation of PA for Oral and Maxillofacial
2016	PB2016-73	Clarification of Orthognathic Surgery Medical Necessity
2016	PB2016-59	Fingerprint based Background Checks
2016	PB2016-52	Phase II-Children's Dental Fee Schedule Reduction
2016	PB2016-45	Phase I-Changes to Children's Fee Schedule for Aug. 2016
2016	PB2016-36	Opioid Legislation
2016	PB2016-27	Changes to Children's Dental Fee Schedule Reimbursement
2015	PB2015-104	2016 Dental Fee Schedule HIPAA Compliant Update
2015	PB2015-51	Changes to the Orthodontic Qualifying Score
2015	PB2015-32	Provider Audit Trainings
2015	PB2015-27	Changes in Dental Coverage for Bitewings
2015	PB2015-15	Dental Regulations Regarding Placement of Amalgam Restorations

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2015	PB2015-06	Hall Technique for the Placement of Stainless Steel Crowns
2015	PB2015-05	Billing Clients for Missed Appointments
2014	PB2014-91	2015 Physician Fee Schedule HIPAA Compliant Update
2014	PB2014-72	Business Associate Agreement Between the Department of Social Services, Vendors and all CMAP Providers
2014	PB2014-71	Tobacco Cessation and New Screening Codes and Program for Dental Hygienists
2014	PB2014-67	Full Activation of Pharmacy and Non-Pharmacy OPR Edits
2014	PB2014-62	Update to Medicaid Dental Services Fee Schedule and Policy
2014	PB2014-52	Updated Provider Re-Enrollment Notification Process
2014	PB2014-46	Expansion of Coverage for Over the Counter (OTC)Products
2014	PB2014-35	Expedited Medicaid Eligibility Processing for Individuals with Medical Emergencies
2014	PB2014-29	Newly Eligible Clients under the Affordable Care Act (Part III)
2014	PB2014-20	**Updated** Implementation of ICD-10 Code Set
2014	PB2014-15	Newly Eligible Clients under the Affordable Care Act (Part II)
2014	PB2014-01	Newly Eligible Clients under the Affordable Care Act
2013	PB2013-82	Incorporation of January 2014 Healthcare Common Procedure Coding System (HCPCS)
2013	PB2013-74	**Updated** International Classification of Diseases, 10th Revision (ICD-10) Implementation
2013	PB2013-64	Implementation of Ordering, Prescribing, and Referring (OPR) Pharmacy Claim Edits
2013	PB2013-60	The Implementation of the Ordering, Prescribing and Referring (OPR) Claim Edits
2013	PB2013-51	Enhanced Editing of Prescribing Provider NPI Numbers
2013	PB2013-31	Elimination of Mailing Paper Remittance Advices
2013	PB2013-24	Implementation of Affordable Care Act Claim Edits
2013	PB2013-15	Transition to the Updated ADA 2012 J434 Dental Claim Form
2013	PB2013-04	Elimination of Paper Re-enrollment Applications
2013	PB2013-03	Electronic Funds Transfer Change Notification
2012	PB2012-59	Performing Provider Enrollment Requirements
2012	PB2012-54	Important Changes to Provider Re-enrollment
2012	PB2012-53	Important Changes to Provider Enrollment
2012	PB2012-46	Change of Dental Fee Payment for Dentures and Resin Fillings
2012	PB2012-42	New Medicaid (HUSKY) Spend-down Procedures
2012	PB2012-38	Change of Dental Benefit Assignment by Dental Provider to Benefit Assignment by Client
2012	PB2012-36	Web Portal Claim History Inquiry
2012	PB2012-31	Change in Procedures for Brand Medically Necessary Pharmacy Prior Authorizations

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2012	PB2012-25	Payment Error Rate Measurement (PERM) Program Audit Requests
2012	PB2012-10	Enhanced Editing of Prescribing Provider NPI Numbers
2012	PB2012-06	Presumptive Eligibility Certification and Guarantee of Payment Form, W-538
2011	PB2011-72	Connecticut's Electronic Health Records (HER) Incentive Program
2011	PB2011-61	Changes to the Dental Fee Schedule and Program Limitations
2011	PB2011-42	Clarification of the Requirements for Pre-screening Client's Eligibility for Orthodontia Treatment
2011	PB2011-36	Definition of Medical Necessity
2011	PB2011-23	HIPAA 5010 Implementation of the 837 Dental Electronic
2011	PB2011-08	Prior Authorization of Post Procedure Review Authorization Appeals Process
2011	PB2011-07	Dental Fee Schedule Changes for Quadrant Designation and for Unspecified Manually Priced Codes
2011	PB2011-01	Prior Authorization and Post Procedure Authorization for Payment Requirements (For FQHC Providers)
2010	PB2010-53	New HUSKY B Client Cost Share for Dental Services (For FQHC Providers)
2010	PB2010-50	Prior Authorization and Post Procedure Authorization for Payment Requirements
2010	PB2010-48	Let e-Prescribing Streamline Your Workflow
2010	PB2010-45	Changes to the Provision of Hospice Services
2010	PB2010-32	Notice of Changes to the Dental Fee Schedule concerning Client Cost Shares for HUSKY B
2010	PB2010-02	Dental Program Changes Pursuant to Public Act No. 09-5
2009	PB2009-57	Correction to Bulletin 2009-25
2009	PB2009-25	Updates to Requirements for Dental Claims Submission
2009	PB2009-07	Got Billing Issues? Schedule a Training Session
2009	PB2009-02	New – Internet Claim Submission is Now Available
2008	PB2008-65	Prior Authorization Inquiry Available on the Web
2008	PB2008-64	Enhanced Fee Schedules Now Available
2008	PB2008-62	Important – Orthodontia Case Completion Billing Changes
2008	PB2008-59	Important – Dental Services Update
2008	PB2008-48	Important – Dental Services Restructuring
2008	PB2008-38	Important – Dental Services Restructuring
2008	PB2008-19	Updated Medicaid Dental Services Fee Schedule and Incorporation of 2009 Current Dental Terminology (CDT) Changes
2008	PB2008-05	Change in Pharmacy Claim Processing for HUSKY Clients
2007	PB2007-76	National Provider Indentifier (NPI) Prescription Requirement Temporary Extension Period for Pharmacy Claim Submission
2007	PB2007-75	Tamper-resistant Prescription Pad Requirement Postponed
2007	PB2007-55	Revision to the Expansion of Dental Providers for Patients of FQHCs
2007	PB2007-31	Escorts for Minors – Non-Emergency Medical Transportation

Date	Bulletin Number	Title
2006	PB2006-103	Addition of Pre-molar Teeth Eligible for Sealant Placement on the Medicaid Dental Services Fee Schedule
2006	PB2006-62	New EPSDT Periodicity Schedule and WIC Coordinators
2006	PB2006-17	Retroactive Fee Increases
2006	PB2006-01	Expansion of Dental Providers for Dental FQHC Clinics
2005	PB2005-56	Update to the Medicaid Dental Services Fee Schedule
2005	PB2005-14	Updated Medicaid Dental Services Fee Schedule
2003	PB2003-102	Updated Medicaid Dental Services Fee Schedule
2003	PB2003-78	Updated Medicaid Dental Services Fee Schedule
2003	PB2003-24	Elimination of Optional Services – When Providers May Bill Clients
2001	PB2001-36	Regulation for Payment of Public Health Dental Hygienist Services
2001	PB2001-18	New EPSDT (Early Periodic Screening, Diagnosis and Treatment Services) Periodicity Schedule and Immunization Schedule
2000	PB2000-81	Dental Procedure Code Changes