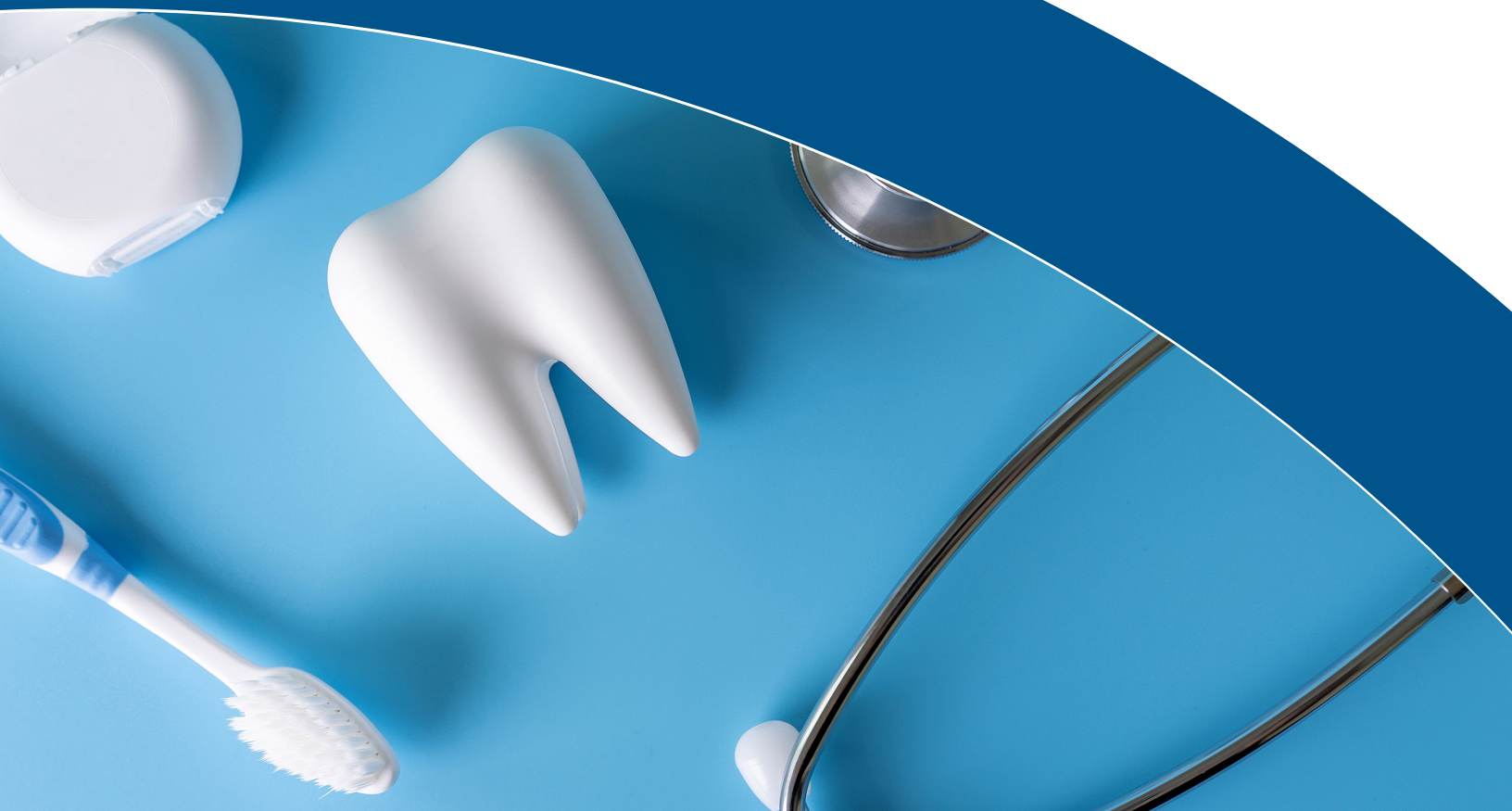
CONNECTICUT DENTAL HEALTH PARTNERSHIP

the dental plan for HUSKY Health

2026 Dental Provider Manual



Version Number	Revision Date	Purpose/Change
6	08/12/2026	Incorporates DSS Dental Regulations 17b-262-1006-17b-262-1017 To request previous versions of the Provider Manual please contact the CTDHP Professional Services Team at 855-CT-DENTAL (855-283-3682)

Table of Contents

Introduction *4*

CHAPTER 1
PROVIDER RESOURCES AND TOOLS 5
Organizations Who Support the Connecticut Dental Health Partnership *5*
Key Contacts *6*
Web Based Tools and Resources *7*
The CTDHP Fee Schedule *8*
The Provider Benefit Resource Tool *9*
Department of Social Services Website – CT Medical Assistance Program (CMAP) *10*

CHAPTER 2
ENROLLMENT AND RE-ENROLLMENT 11
Enrollment / Re-enrollment Process *11*
CT DSS Online Enrollment Tool *11*
Dental Taxonomy Assignment *12*
Paper Enrollment Process *12*

CHAPTER 3
DEPARTMENT OF SOCIAL SERVICES MEDICAID MEDICAL SERVICES - DENTAL POLICY OVERVIEW 13
Dental Regulations *13*
Key Terms and Definitions from Department of Social Services Dental Regulations and Policy *14*

CHAPTER 4
PROVIDER OPERATIONS - STANDARDS AND PRACTICES 19
Appointment Scheduling *19*
Opening and Closing Panels *19*
Patient Record Sharing *20*
Charging and Billing for Goods and Services *21*
Provider Billing/ Claims Processes *22*
Periodic Provider Surveys *22*
Utilization Management *23*
Marketing Guidelines *24*

CHAPTER 5
PROCESS AND PROCEDURES 27
Authorization Requirements *27*
Key Terms *28*
Appeals *31*
Adult Annual Benefit Maximum *33*
Coverage Guidance on Commonly Performed Services that Require Prior-Authorization *35*

CHAPTER 6
CONNECTICUT DENTAL HEALTH PARTNERSHIP SERVICES AND SUPPORTS TO PROVIDERS 54
Professional Relations and Network Development *54*
Authorization Services and Provider Support *55*
Member Care and Community Connection Teams *56*
CTDHP Population Health and Data Reporting *58*

CHAPTER 7
FREQUENTLY ASKED QUESTIONS 59
Billing & Claim Submission *59*
Authorization for Services *60*
Continuity of Care and Member Eligibility *62*
Specific Services and Member Scenarios *63*
Orthodontia Services *65*

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).

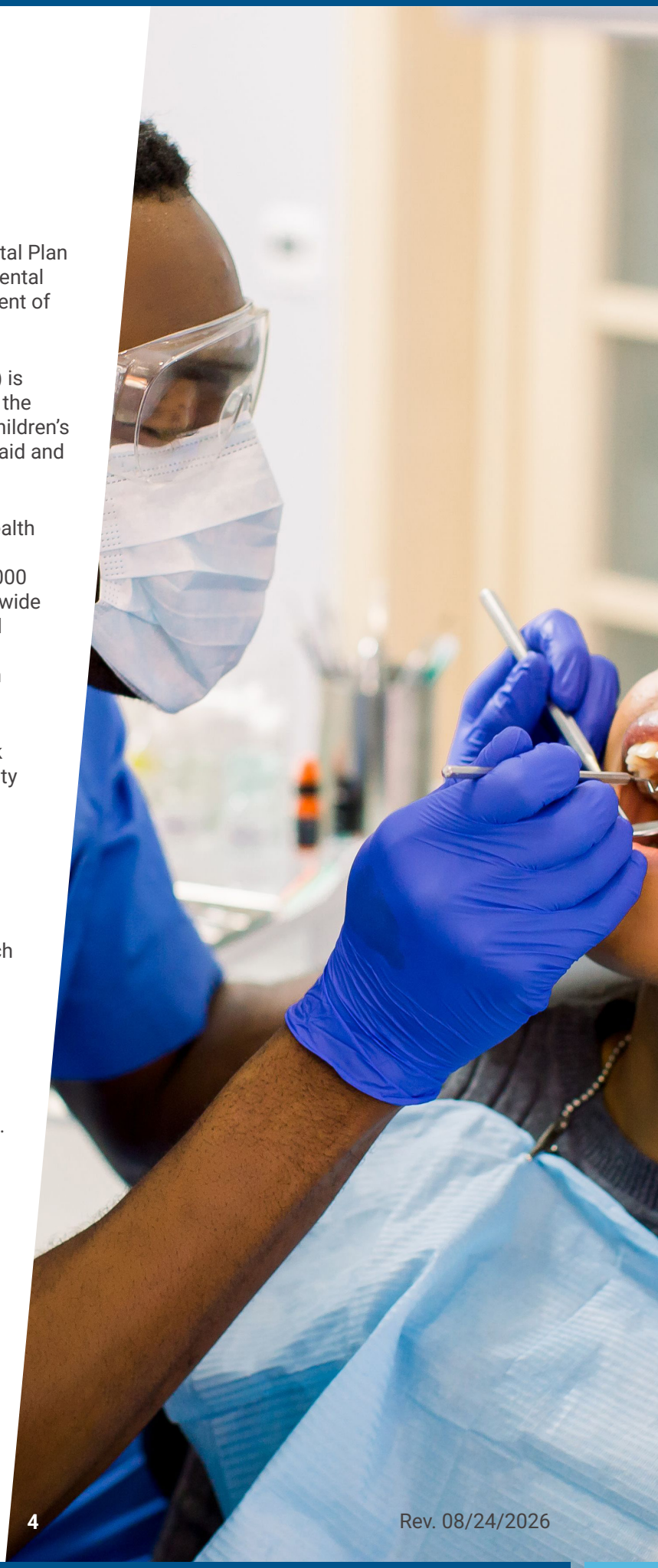
The Connecticut Department of Social Services (DSS) is the single state agency responsible for administering the Connecticut Medicaid Assistance Program and the Children's Health Insurance Program (CHIP). Collectively, Medicaid and CHIP are known as the HUSKY Health Program.

CTDHP administers the dental benefits for HUSKY Health and Covered CT members and operates a responsive Member Services Call Center serving more than 900,000 Connecticut residents. CTDHP also maintains a statewide team of Community Engagement Specialists and Oral Health Navigators who provide provider education, member outreach, and assistance for individuals with complex oral health care needs.

CTDHP oversees a comprehensive statewide network of dental providers committed to delivering high-quality oral health services to HUSKY Health and Covered CT members.

In addition, CTDHP administers the Grievance and Appeals process. Dedicated Grievance and Appeals Representatives assist members in understanding coverage determinations and guide them through each step of the grievance and appeals process to ensure access to appropriate care.

The Connecticut Dental Health Partnership'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.



CHAPTER 1 *Provider Resources and Tools*

The Connecticut Dental Health Partnership (CTDHP) offers a variety of tools and resources designed to help Providers efficiently navigate and participate in the HUSKY Dental Plan. These resources are intended to simplify administrative processes, support clinical decision-making, and enhance overall practice operations. Many of the tools and resources are available online for convenient access. This chapter outlines the available resources and provides step-by-step guidance on how to locate and use them to support your participation in the HUSKY Dental Plan.

Organizations Who Support the Connecticut Dental Health Partnership

The HUSKY Dental Plan and Their Role

There are three primary organizations that work to maintain the HUSKY Dental Plan. As an enrolled provider you may interact with these organizations in different capacities. Outlined below is a listing of those organizations and their role.

Organization	Role	Key Functions
CT Department of Social Services (DSS)	Responsible for the administration and management of the Connecticut Medicaid and The Children's Health Insurance Program or HUSKY Health.	• Member eligibility and enrollment • Designs coverage guidelines, policy, and regulations • Fiscal budget administration and maintenance of the federal-state partnership that covers the costs of services • Fiscal and programmatic integrity of HUSKY Health through Office of Quality Assurance and Medicaid Recovery Audit contractor • Oversees Administrative Hearings for member appeals • Vendor management of the Medicaid Administrative Services Organizations (ASOs) and other contractors who support program administration and quality improvement
Gainwell Technologies	Responsible for managing the Medicaid Management Information System (MMIS) including the business and fiduciary functions of HUSKY Health.	• Provider Enrollment/Re-Enrollment • Claims Submission and Processing • Provider Relations and Training • Primary Source for Provider Manual, Fee Schedules, DSS Policy Bulletins, and Important Messages

Organization	Role	Key Functions
BeneCare Dental Plans	Responsible for administering the Connecticut Dental Health Partnership as the Dental Administrative Service Organization (ASO) vendor.	• Member and Provider Call Center • Provider Recruitment, Education, and Retention • Authorization Processes • Operates Member Appeals Processes • Utilization Management • Member and Community Engagement • Oral Health Navigation • Medical-Dental Integration Programs • Performance and Quality Improvement • Population Health and Provider Network monitoring and reporting
Community Health Network of Connecticut Inc.	Responsible for administering the medical services as the Medical Administrative Organization (ASO) vendor.	• Authorization Processes for Medical services including certain dental related medical services e.g., major oral surgery, oral cancers, or trauma related procedures and durable medical equipment known as CT MEDS

Key Contacts

Contact	Phone Number
CTDHP Constituent Services Call Center (For Members and Providers) Our 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.	855-CT-DENTAL (855-283-3682)
CTDHP Fax	860–674–8174
CTDHP 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 E City Avenue Ste 600
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

Web Based Tools and Resources

Resource	Link	Step-by-Step Guides
CTDHP Main Website	https://ctdhp.org/	
CTDHP Fee Schedule	https://ctdhp.org/dental-fee-schedule/pdf/	
CTDHP Provider Benefit Resource Tool	https://ctdhp.org/provider-benefit-resource/	How to Use the Provider Benefit Resource Tool
CTDHP Secure Provider Portal	https://ctdhp.org/dental-providers/login/	
Provider Authorization Submission		Submitting a Prior Authorization Request
Periodontal Authorization Submission		How to Submit an Orthodontic or Periodontic Prior Authorization Request
Orthodontia Authorization Submission		
Member Eligibility Look Up		How To Check Member Eligibility and Dental Treatment History
Member Dental Treatment History Look Up		
Member Medical Claims History Look Up		How to Access Medical Claims History Report
Checking Authorization Status		How to Check Prior Authorization Reports
CTDHP Secure Oral Health Navigation Referral Portal	https://ctdhp.org/refer-a-client/	

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

The Fee Schedule is found here: **https://ctdhp.org/dental-fee-schedule/pdf/**

Special Note: 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(s)
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

Special Note: 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.

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

Note: An *empty* cell on the fee schedule signifies that no prior authorization is required.

The Provider Benefit Resource Tool

The Provider Benefit Resource Tool is a searchable application that identifies and describes all Medicaid-covered dental services. It serves as a centralized reference that supplements the Provider Manual by offering detailed, service-specific guidance, including:

- Category of Service
- Procedure Code and Description
- Applicable Fees and Copayments
- Providers Eligible and Ineligible to Perform the Service
- Providers Required to Submit Prior Authorization
- Service-Specific Coverage Limitations
- Coverage Guidelines
- Prior Authorization Submission Requirements
- History of Related Policy or Guidance Changes

The Provider Benefit Resource Tool is accessible here: **https://ctdhp.org/provider-benefit-resource/**

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, member 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**.

SPECIAL NOTE: To get the latest information from the Department of Social Services CMAP including policy bulletins and alerts – register to receive their online publications on the website under Provider "e-mail subscription".

CHAPTER 2 *Enrollment and Re-enrollment*

Enrollment / Re-enrollment Process

Dental providers are required to enroll via the Department of Social Services CMAP secure web portal you can access at: **https://www.ctdssmap.com/ctportal/provider/provider-enrollment**

The CT Dental Health Partnership offers personalized assistance with the Department of Social Services Enrollment and Contracting processes.

By contacting **CTDHP** at **855-CT-DENTAL (855-283-3682)**, we will work with you and your office staff to get your office enrolled or re-enrolled with the CMAP/HUSKY Dental 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 (DSS)

For the most up to date enrollment requirements, please consult the Connecticut Department of Social Services website: **ctdssmap.com**.

CT DSS 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

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 (Pedodontics)	1223P0221X
Periodontist	1223P0300X
Public Health Dentist	1223D0001X
Prosthodontist	1223P0700X
Dental Resident in Training Program	390200000X

Paper Enrollment Process

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.

CHAPTER 3

Department of Social Services Medicaid Medical Services – Dental Policy Overview

Dental Regulations

Regulations governing the payment of dental services under Connecticut's Medicaid program are promulgated and implemented by the Department of Social Services. (Regs. Conn. State Agencies §§ 17b-262-1006 to 17b-262-1017)

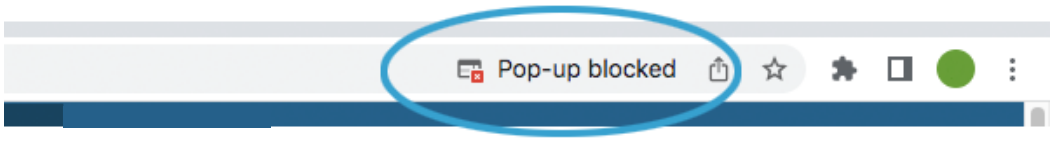
Chapter Seven of the Connecticut Medical Assistance Program contains the current dental regulations that CTDHP uses as the framework to make benefit determinations for covered dental services, ensure compliance with standards set forth in the regulations, and to administer the dental program.

Any updates to state regulations and 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 the below and **ALLOW** the pop ups. This could be on the right or left top of your screen depending on your browser.)



Key Terms and Definitions from Department of Social Services Dental Regulations and Policy

Provider and Practice Focused Definitions and Guidance

Term	Definition and Guidance
Dental Clinic	A facility that has been issued a license by the Department of Public Health to operate a clinic to provide comprehensive dental services to members on an outpatient basis.
Dental Home	A Dental Home must meet the following qualifications to be considered a Dental Home: • Provide comprehensive care (restoration of cavities, root canal therapy, prosthetic services and extractions) in addition to primary dental care prevention and emergency services • Be accessible and have a fixed location within a twenty-mile radius of the patient base and have regularly scheduled appointment hours available weekly including the summer months • Have a plan for providing emergency care after regularly scheduled office hours twenty-four hours a day, seven days per week, other than simply providing a referral to the local hospital emergency room • Have the capacity to make referrals to specialists if needed, within the patient's established dental plan's network
Primary Care Dentist	A licensed, enrolled dentist who is primarily responsible for the delivery of comprehensive dental services to members and when necessary, coordinates the care of a patient between other dental and medical specialists. The primary care dentist functions as the dental home for patients of record. A pediatric dentist can be considered a primary care dentist for children ages zero through twenty (0-20)
Dental Specialist	A dentist who has taken and passed the required practicum for dental licensure and received and successfully completed a post graduate training program accredited by CODA leading to a certificate, master's degree in dental science, board eligibility or board certification in any of the following specialty areas of dental medicine: Anesthesiology, Dental Hygienist, Endodontology, Oral Pathology, Oral Radiology, Oral Surgery, Orthodontics, Pediatric Dentistry, Periodontist, Prosthodontic, Public Health Dentist, General Dentist
Dental Specialty Practice	A practice that holds itself out as a specialty practice, offers selective dental services concurrent with a dental specialty that is recognized by the ADA. The dentist must have obtained a degree or certificate in a specialty or interest area from a CODA accredited training program. The practice will provide the services that are deemed to require advanced knowledge and skills that are essential to maintain or restore oral health. This includes anesthesiology, endodontics, oral surgery, orthodontics, pediatric dentistry, periodontics or prosthodontic services. Dental Specialty Practices shall: • Employ at least one dental specialist; • Have a dental specialist on site at all times when the practice is open and providing services to Medicaid enrolled members, particularly if the practice employs a dentist who is not a specialist; and • Comply with prior authorization and post procedure review requirements listed on the Medicaid fee schedule for any dentist who is not a specialist but provides specialty services.

Term	Definition and Guidance
Public Health Dental Hygienist	A hygienist who is licensed to practice dental hygiene, enrolled in the Connecticut Medical Assistance Program, and elects to practice independently from a dental practice to provide services in a public health facility. Additionally, the Public Health Dental Hygienist must meet Scope of Practice Guidelines identified in the Connecticut General Statute including possessing two years of experience to work without a dentist's supervision and must coordinate the referral for treatment to dentists.
Mobile Dental Clinic	To be reimbursed for services conducted at a Mobile Dental Clinic the following items must be implemented: • Have or contract with a fixed location • Provide or place referred patients into comprehensive dental care for services such as restorations, endodontic treatment or extractions. The dentist must be able to handle emergencies on a 24-hour, seven day a week basis; • Be limited to submitting claims for services provided within a geographic area that is not more than thirty miles from the associated dentist's fixed dental location, except that a mobile dental clinic in the counties of New London, Litchfield and Windham may submit claims for Medicaid reimbursement for dental treatment of Medicaid beneficiaries not more than 50 miles from the dentist's fixed location; • If the member has a dental home, the mobile clinic shall consult with the dentist of record before providing any treatment to the members; • Obtain consent from the member's legal guardian before rendering treatment to a member under the age of eighteen; • Have all written materials available in English and a proficient Spanish version written at no greater than a seventh-grade reading level

Term	Definition and Guidance
School Based Health Center Dental Services	To be reimbursed for services conducted at a School Based Health Center the following processes must be implemented: • Process to obtain consent from the member's legal guardian before rendering treatment to a member under the age of eighteen and comply with the following requirements; - All permission slips shall clearly state that the services being offered are in coordination of care with the member's dental home - The permission slip shall be valid for one year, which shall be specified on the permission slip, and shall clearly state that the parent or guardian may revoke their consent at any time; and - The permission slip may include a list of procedures that may be provided at the school-based health center and shall include the option for the parent or guardian to opt out of certain procedures • Review each member's service history before rendering treatment, if available. If the member has a dental home, the school-based health center shall consult with the dentist of record before providing any treatment to the members; • Refer members into comprehensive dental care for services such as restorations, endodontic treatment, or extractions; • Have all written materials available in English and a proficient Spanish version written at no greater than a seventh-grade reading level; • Have all written materials available in oral and written form in languages other than English as required by 45 CFR 92.101 • Make all records and imaging available to any authorized requester within five days of the request. In the event of an emergency, the SBHC shall provide the requested records to the authorized requester within twenty-four hours of receipt of the request

Reimbursement Focused Definitions and Guidance

Term	Definition and Guidance
Prior Authorization (PA)	Approval from the department or its designee for the provision of a service or the delivery of goods before the provider provides the service or delivers the goods.
Post Procedure Review (PR)	The post treatment assessment of specified services after the services have been performed to verify proper coding has been submitted for the procedure, and that procedures performed comport with program coverage guidelines and the prevailing standards of care. Procedures subject to review shall include, but not be limited to, those procedures which are performed on an emergency or urgent basis.

Term	Definition and Guidance
Supporting Documentation	Additional information that is required to conduct authorization reviews by CTDHP Dental Consultants. Per Regulations they include: • Charted records of the dentition and soft tissue; • Documentation of a condition or disease state from another healthcare provider or agency; • Models of the dental arch with bite registration when appropriate; • Photographs electronically or printed on photographic paper; • Diagnostic imaging; • Treatment notes; • Post procedure review requests shall contain the date of service; • Any teeth expected to be extracted shall be documented on the prior authorization or post procedure review claim form; • Fully developed individualized treatment plans that contain phase one, two, and third stage of treatment
Medical Necessity* (See definition on the following page)	As it relates to authorization requests (PA or PR) within the regulations, the Department or CTDHP determines what information is necessary to approve authorization requests, provided such determination includes a finding of Medical Necessity and is consistent with covered services identified in the dental regulations. Definition of Medical Necessity is further defined in this chapter.
Usual and Customary Charge	The amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in a majority of cases, “usual and customary” means the median charge. Token charges for charity patients and other exceptional charges are to be excluded.
Utilization Management	The post claim or post payment compilation and assessment of aggregated services delivered by providers after the services have been performed. An objective, qualitative computer-based regression is conducted to determine through statistically significant measures if the services delivered to members are appropriate.
Non- Covered Services	Services that are not covered by Medicaid and will not be reimbursed and/or are prohibited to be charged to a patient. See Chapter 4 under Charging & Billing for Goods or Services for further detail.

Defining 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 DSS 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 DSS 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

CHAPTER 4

Provider Operations - Standards and Practices

Identified below is a summary of standards articulated in your contract, Department of Social Services regulations and policies, and operational best practices, all of which support HUSKY Health members in receiving quality oral health care.

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 NOT EMERGENT CARE VISITS** shall be scheduled within **eight weeks** (56 Days) of the initial request
- **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 members cannot be charged for missed or cancelled appointments**

In order to ensure the best possible member 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 member 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 member 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 members 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 CTDHP at **855-CT-DENTAL (855-283-3682)** for assistance.

Patient Record Sharing

Section 20-7d of the Connecticut General Statutes requires that 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 member is allowed. We ask that the fee be waived for our members.

The Connecticut Dental Health Partnership (CTDHP) and its authorized representatives may request copies of a patient's records, or records for multiple patients, as part of their program responsibilities. A HIPAA release is not required for these disclosures, as CTDHP is considered a covered entity/business associate for the purposes of care coordination and program administration. All requested information must be provided promptly to ensure timely coordination of care and compliance with program requirements.

Chart Documentation and Record Keeping

The Member's chart and dental records must contain the following information:

- The member's full name, first, middle, and last name;
- The member's residential and mailing address;
- The member's date of birth;
- The member's phone number;
- The member's Medicaid identification number and social security number;
- Third party insurance coverage, if applicable;
- Medical history, including a listing of current pharmaceuticals;
- Charting of the member's present and missing teeth;
- Charting of the member's restorations, fixed dental appliances and removable prosthetic appliances for general dentists, pediatric dentists, prosthodontists, and public health dentists;
- Charting of the member's periodontium for general dentists, prosthodontists, periodontists, and public health dentists;
- The treatment plan for the member and a signed consent form;
- The date and written or electronic signature with each entry in the member's dental chart. Initials are not acceptable;
- Full description of the procedure(s) performed, including the location (tooth number, soft tissue location), techniques or materials used in the procedure, if applicable, that justifies the Current Dental Terminology Code used for the procedure billed;
- Notes regarding any diseased states, unusual circumstances or conditions;
- For periapical and/or other images, that is images that are not taken in conjunction with a complete or full mouth series, the provider shall document the reason for taking the periapical image or other images and include the tooth number;
- All imaging shall be properly labeled and shall include the date the images were taken, the reason why the image was taken and the interpretation of the imaging by a licensed dentist;
- The member's diagnosis, vital signs and the reason for the procedure being performed on each date of service;
- A copy of any required departmental dental forms;
- Records may be kept in electronic format or in paper chart format, but diagnostic imaging or images stored in an electronic format must be maintained in a state that can reproduce the diagnostic quality. Offsite storage of the patient record contents is acceptable if the documentation can be accessed as needed

Patient's record and information shall be made available to representatives of the Connecticut Dental Health Partnership upon request.

Charging and Billing for Goods and Services

Providers **CANNOT** charge a **HUSKY Health Member** or any financially responsible relative or representative for:

- Cancelled, Missed, or Scheduling of Appointments
- Any portion of the cost of goods or services which are covered and payable under Medicaid/HUSKY.
- If a Member or representative has paid for goods or services and the member subsequently becomes eligible for the medical assistance program, payment made by or on behalf of the Member 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
- Any procedure that is an upgrade to the Medicaid/ HUSKY Dental covered procedure
- Balance Billing for a service covered or billed to Medicaid/HUSKY Dental
- For medical goods or services for which a member would be entitled to have payment made, but for the provider's failure to comply with the requirements for payment established by state regulations

Scenarios in which Providers may charge a HUSKY Health Member or any financially responsible relative or representative:

- Any service or good that is not covered or approved by Medicaid may be paid for by a Member if they choose to undergo treatment as a private paying patient. The member must knowingly elect to receive the goods or services and enter into an agreement in writing for such goods or services prior to receiving them. Please note: Effective January 2027, per Public Act 26-06, Members may choose to pay with a medical credit card (such as CareCredit) – however, health care providers cannot influence their decision to utilize such a card if the member has not already made that decision for themselves
- The Provider must make a clear and concise written agreement at the initial treatment planning of the procedure with the member regarding financial responsibility due to the service not being covered by Medicaid and include a payment schedule if applicable for the non-covered procedure

Providers CANNOT bill Medicaid/ HUSKY Dental for:

- Cancelled, Missed, or Scheduling of Appointments
- Any procedure or service which is not listed on the dental fee schedule unless the provider submits a request for prior authorization and provides required medical documentation establishing the member's medical need for the requested service
- Any procedure that has been attempted but not completed
- Any procedure that is an upgrade to the Medicaid covered procedure where the member is balance billed for the difference
- Any service divided into smaller components of treatment that is by common definition and standards of care included in a single CDT code
- Unbundling of a group of procedures normally performed in a single visit as is the standard of care
- Services that are experimental, of a research nature, or that are not proven as a safe or effective as documented by peer review literature or best practices
- Services more than those deemed medically necessary by the department to treat a member's condition or for services not directly related to the member's diagnosis, symptoms, or medical history
- Service, procedures, or dentures not provided

Provider Billing/ Claims Processes

All dental services performed that do not require prior authorization or post procedure review are to be billed to the Department of Social Services (DSS) claims processing vendor (Gainwell Technologies) 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.

Services performed that do require authorization are to be submitted to CTDHP via the CTDHP secure Provider Portal website at **https://ctdhp.org/dental-providers/login/**

The claim submitted is to be the amount billed that represents the provider's usual and customary charge for the service rendered.

If the provider does not charge usual and customary fees and retroactive mass adjustment is made, the Department of Social Services will not compensate a provider for the difference between the adjustment and the fee billed.

Timely filing for all dental claims is **365 days** from the date of service.

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.

Periodic Provider Surveys

CTDHP will contact providers to ensure that the information on file for each office remains accurate. The 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.

Providers are encouraged to contact CTDHP with any updates to services, address, phone numbers, and languages spoken or special accommodations at any time of the year. This can be done by contacting the Professional Services Team at 855-CT-DENTAL (855-283-3682) or completed online in the CTDHP Provider Portal (**https://ctdhp.org/dental-providers/login/**) by selecting **"Update Office Info"**.

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 industry standards of sterilization, charting, quality of care and patient safety. After a visit is completed, results and any improvement opportunities will be shared with you.

Utilization Management

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 program's 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.

are 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 member 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

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 (DSS) 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 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 DSS 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 members are subject to review. Submissions should include a description of the proposed marketing approaches, strategies, tactics and channels.

The State of Connecticut logo, DSS logo, or any program logos and/or names in private marketing materials which target CTDHP members 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 DSS.

Corporate marketing materials that include the DSS' 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 (DSS) 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 members 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 DSS 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 member 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 member/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 members 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, Member 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 member shall not knowingly exceed five 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 members, patients of record or potential patients
- Gifts of any kind to agencies including DSS or its designee that hosts meetings with members 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.

CHAPTER 5 *Process and Procedures*

This chapter outlines the administrative and clinical processes that govern authorization, documentation, review, and reimbursement for dental services provided under the Connecticut Dental Health Partnership (CTDHP) for HUSKY Health members. It is intended to guide providers in navigating authorization requirements, submitting complete and timely documentation, understanding coverage parameters of more common treatment services, and following established pathways for review, approval, and appeal. The policies described herein are designed to support consistent application of Connecticut Department of Social Services (DSS) regulations while promoting access to medically necessary care, efficient practice workflows, and responsible stewardship of Medicaid resources. Providers are encouraged to use this chapter in conjunction with the tools and references identified throughout the manual to ensure compliance, minimize delays in care delivery, and facilitate treatment planning that restores members to functional oral health.

Authorization Requirements

CTDHP administers the dental authorization process on behalf of the Connecticut Department of Social Services. Whether conducted as a prior authorization or as a post-procedure review, CTDHP evaluates requested or rendered dental services in the context of each member's dental treatment history, current oral health status, medical conditions, and behavioral health considerations. Reviews assess adherence to dental professional standards of care and best practices, compliance with CDT coding definitions, and alignment with HUSKY program benefits and guidelines as outlined in the Connecticut Dental Regulations. All determinations are guided by the HUSKY Dental Program's philosophy of restoring members to a functional—not cosmetic or aesthetic—oral health status in the least costly manner that is medically and clinically appropriate.

CTDHP aims to ensure providers have a clear, complete, and transparent understanding of service and coverage guidelines so they can make timely clinical decisions without delaying medically necessary care due to authorization requirements. To support prompt treatment—particularly in emergent and urgent situations—services that normally require prior authorization may be submitted for post-procedure review.

Coverage and authorization requirements vary based on member age, rendering provider type or specialty (as determined by taxonomy), and the specific procedure. Providers are strongly encouraged to use the tools outlined in Chapter 1, Provider Tools and Resources, to accurately determine coverage and authorization requirements.

Key resources include the Dental Fee Schedule and the Provider Benefit Resource Guide produced by CTDHP and the Gainwell Fee Schedule.

Key Terms

Authorization Submission Request *(also known as a Claim Request)*

Providers may submit authorization requests on paper or electronically. CTDHP highly encourages electronic submission over mailed/ paper submissions.

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.

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

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

Do not submit Authorization Requests to Gainwell (DSS Claim System) for processing.

Emergency Requests

In the event an emergency prior authorization is needed for endodontic therapy (root canals) and the replacement of a filling that is less than a year old please contact CTDHP Provider Service Representatives at 888-445-6665 (8:00am to 5:00pm, Monday through Friday) for assistance in determining if the service will meet the state's medical services regulations and policy.

Please have the following information ready:

- Provider Name and NPI of the billing entity and performing provider
- Member's Name
- Member Date of Birth and Medicaid ID
- Proposed procedure(s)
- Proposed treatment plan
- Presence or absence of the Member's teeth

Supporting Documentation

Please reference the Provider Benefit Resource Tool for procedure specific documentation. In general, required supporting documentation is to include:

- Charted records of the dentition and soft tissue;
- Documentation of medical condition and appropriate medical diagnosis from another healthcare provider or agency;
- Models of the dental arch with bite registration when appropriate;
- Photographs electronically or printed on photographic paper;
- Diagnostic imaging- all images must be properly labeled and dated;
- Treatment notes;
- Post procedure review requests must contain the date of service and properly labeled documentation;
- Any teeth expected to be extracted shall be documented on the prior authorization or post procedure review claim form.

Please Note: With paper submission please 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.

Fully developed individualized treatment plans that contain phase one, two and the third stage of treatment shall be presented for review and approval with any combination of endodontic or prosthodontic services that require prior authorization. The plan must be clear and include all teeth to be restored or extracted.

Failure to provide a treatment plan will result in a denial of services.

Missing, illegible, or unlabeled documentation will require resubmission and slow the review process and member care delivery.

Submissions lacking required documentation, that are illegible or are not appropriately labeled will be entered in a pended status. A request for the missing or appropriate documentation will either be mailed to the submitting dentist or updated in the PA Portal Status.

Care delivery is slowed when submissions are pended!

Review Process

CTDHP's dental consultants will review the submission and accompanying documentation in order to determine if requests for 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

Allow **fifteen (15) business days** for the review and processing of prior authorization and post procedure review requests.

Guidance is to schedule patients at **least four (4) weeks** out from the date of submission.

Determinations will be available in the PA Portal Status and sent via mailed letter; as they both contain the same determination, you do not have to wait for the mailed letter to arrive if you see the determination in the PA Portal Status.

Waiting on the mailed letter can delay care.

Approved Authorizations

Members receive notice of approved PAs in their CTDHP Secure Member Portal.

Approved prior authorizations/post procedure reviews will be sent to Gainwell and will reflect the billing dental provider identifier, member ID and procedure code(s) approved. After receipt of authorization and completion of services, the provider must submit their claim for services to Gainwell for payment.

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.

Procedure codes for services that are found to be "up-coded" or unbundled as determined by CTDHP will be corrected and the authorization information for those procedure codes will be transmitted to Gainwell reflecting the properly coded procedures.

Services that are authorized are specific to the provider and to the Member. Only those procedure codes will be paid. Submittal of different procedure codes, Member Medicaid identification number, provider billing NPI number from what was submitted and approved will result in a denial of payment.

If the member selects another dentist to perform the service after the authorization is approved a new authorization is needed. The dental office which was granted the prior authorization must release the PA to the new office by calling the CTDHPs Prior Authorization Provider Representatives at (888)-445-6665

Denied Authorizations

Providers will receive notification of denials via mailed letter and in the PA Portal.

Providers can request reconsideration and appeal via established process. See detailed processes further in this chapter regarding appeals.

Members have a separate and different appeals process that are outlined in the Member Information section of the CTDHP website and through the Notice of Action (NOA) documentation that is mailed.

Federally Qualified Health Centers (FQHC) Authorization Process

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' member 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 is 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.

View the FQHC Authorization Process Guide at the below link:

https://ctdhp.org/wp-content/uploads/2025/04/fqhc_overview_v6_05262026.pdf

Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Authorizations

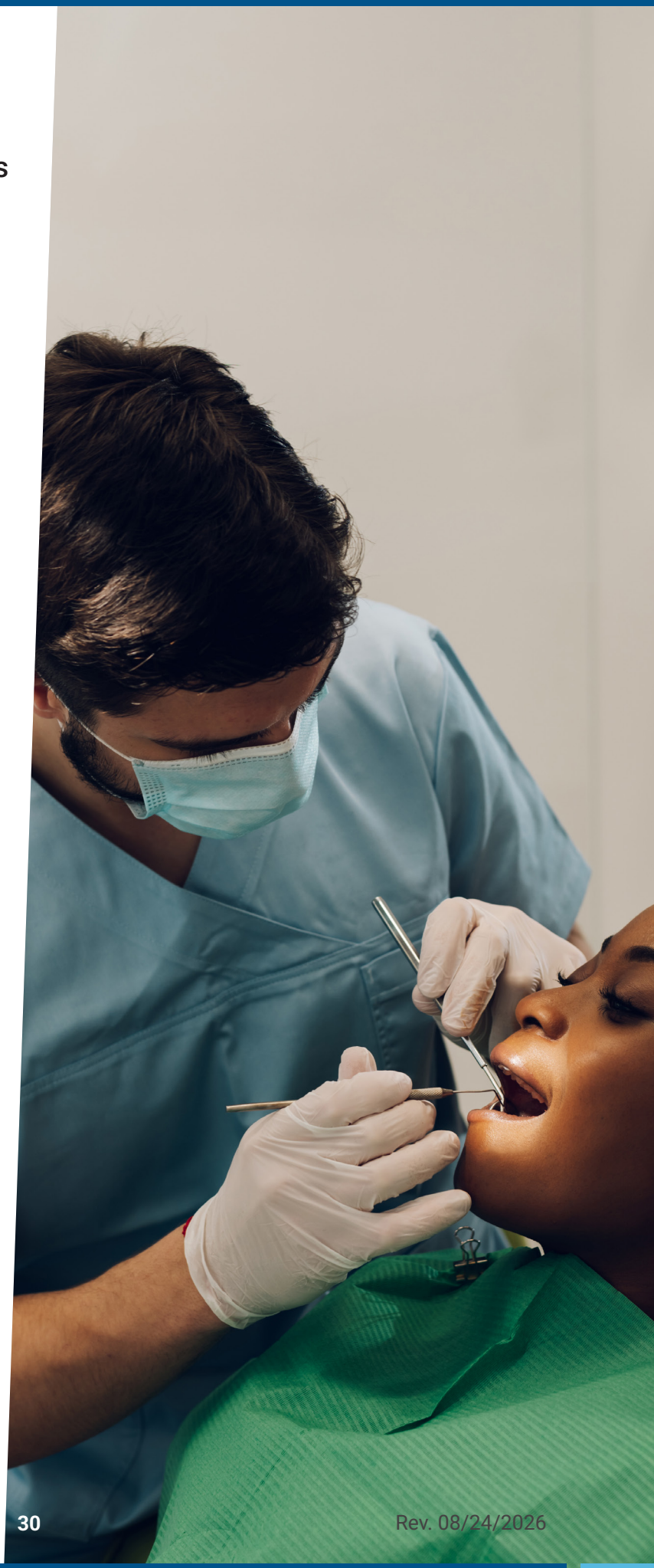
The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program is a federally mandated component of Medicaid/CHIP for children under age 21, with an emphasis on prevention, early diagnosis, and treatment. For dental care, EPSDT requires that services be provided at intervals consistent with reasonable standards of dental practice; not be limited to emergency services; and be covered when medically necessary. Required dental services include:

- Relief of pain and infection
- Restoration of teeth
- Maintenance of oral health

EPSDT regulations mandate coverage of any medically necessary dental service for members under age 21, even if the service is not included in the state Medicaid plan or listed on the fee schedule.

To request an EPSDT-related service not listed on the fee schedule for members under age 21, providers must follow standard prior authorization (PA) submission processes and indicate EPSDT/ Title XIX on the PA claim form or within the PA portal. Standard authorization review processes apply.

Connecticut's EPSDT dental periodicity schedule, developed by CTDHP, closely aligns with the American Academy of Pediatric Dentistry guidelines for examinations, preventive services, and anticipatory guidance. The schedule is available on the CTDHP website under the **HUSKY Dental EPSDT Periodicity Schedule for Children**.



Appeals

When a prior authorization request is denied or a post procedure review is down-coded, your office has the ability to request a reconsideration of the PA or PR procedure. 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 Husky Health Members and the dentists have independent and different appeal rights. Members 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 HUSKY Health Member is found to be ineligible for services due to administrative reasons. For example, the Member may no longer be enrolled in Medicaid, or the Member has not met the spend-down amount needed to become enrolled in the Medical Assistance Program. Other reasons for administrative denials may include reasons such as the failure to follow administrative procedures.

An administrative appeal may be made in writing or via the telephone (888–445–6665). 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 (10) business days. The notification will state if the original determination was upheld or the decision was made to overturn the denial.

Clinical Denial Appeals

Clinical denials occur when it has been determined by the BeneCare Dental Consultant that the service does not meet medical necessity reasons, does not comply with the prevailing standard of care, or it is believed there is an alternative less expensive but appropriate treatment that will restore form or function to the member.

THE APPEALS PROCESS IS AS FOLLOWS:

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 (7) 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 (5) 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 (7) business days from the date of issuance of the denial notification. Level two appeals will be considered by the DSS Dental Director, CTDHP 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:** A level three appeal is your request after receiving denials from level one and level two appeals. Level three appeals must be submitted in writing no later than seven (7) business days from the date of issuance of the denial notification. Level three appeals will be reviewed by the University of Connecticut School of Dental Medicine Faculty.

   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.

4. **Level Four 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 (7) 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 (CSDA) in accordance with the Department of Social Services Medical Services Policy 184G.I. There are no further appeal rights beyond the CSDA.

   Turnaround time: Notifications of the decisions from external review will be issued within ten (10) 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 E City Ave, Suite 600
Bala Cynwyd, PA 19004

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

Adult Annual Benefit Maximum

The HUSKY Dental Program applies a $1,000 annual dental benefit maximum for adults (over the age of twenty-one (21)) enrolled in HUSKY A, C, and D. The benefit maximum is intended to support a comprehensive adult dental benefit while ensuring responsible stewardship of Medicaid resources.

Providers should continue to submit prior authorization requests for medically necessary services regardless of a member's remaining annual benefit balance or whether the member has reached the $1,000 annual benefit maximum. Reaching the annual benefit maximum does not automatically result in denial of medically necessary services. Requests for medically necessary care will continue to be reviewed through the prior authorization process and may be approved when clinical criteria are met.

This policy is intended to preserve access to medically necessary treatment while encouraging preventive care and disease-management-focused treatment planning.

Important Facts:

- The maximum is calculated on a calendar-year basis (January 1–December 31)
- The benefit **resets every year on the first of January**, regardless of the date services were initiated
- The $1,000 limit is **cumulative across all providers** treating the member
- When a Member turns 21, the accrual will begin with all adjudicated claims on and after their 21st birthday, through December 31st of that year
- Any service or cumulative services that exceed the annual maximum are allowed **when that service is determined to be medically necessary**
- Members are contacted by CTDHP **when their annual benefit reaches $600** and again **at $900 by the State of Connecticut** to proactively inform and educate the member including when appropriate work with the CTDHP Oral Health Navigation or Member Services team to connect to care

Certain emergency, hospital based, diagnostic and treatment services **are not** counted towards the annual dental benefit maximum. See listing of codes below. **Please note authorization rules still apply.**

D0180	Comprehensive Periodontal Evaluation
D0191	Assessment of a Patient
D0365-D0368	Cone Beam CT
D0372-D0373	Tomo Images
D0412	Blood Glucose Level Test
D1320	Tobacco Counseling
D4341-D4342	Periodontal Scaling and Root Planning
D4355	Full Mouth Debridement
D4910	Periodontal Maintenance
D5110	Complete Denture- Maxillary
D5120	Complete Denture- Mandibular
D5931-D5932	Obturator Prothesis
D7111	Extraction – Coronal Remnants
D7260	Oral Antral Fistula Closure

D7261	Primary Closure of Sinus Perforation
D7410	Excision of Benign Lesion
D7411-D7441	Excision of malignant lesions
D7450-D7465	Removal of benign cysts
D7510-D7521	Incision and drainage of abscess
D7530-D7540	Removal of foreign body
D7630-D7871	Surgical codes
D7910 – D7949	Surgical codes
D9110	Palliative treatment (Emergency)
D9410	House/Extended Care facility call
D9420	Hospital call
D9613	Infiltration of sustained release therapeutic analgesic
D9953	Reline sleep apnea appliance
D9997	Dental case management – patients with special health care needs

Provider Responsibilities

- Monitor each Member's accumulated annual benefit usage throughout the year. Verification may be completed through the CTDHP Treatment History function in the secure Provider Portal or through the secure provider portal at **ctdssmap.com**.
- Proactively discuss treatment planning, sequencing of care, and coverage limitations with Members
- Request prior authorization when clinical needs are expected to exceed the annual benefit maximum
  - If approved, authorized services are reimbursed by Medicaid and may not be billed to the Member

If services are not approved and all applicable appeal processes (for either the Provider or the Member) have been exhausted, the Member may choose to assume financial responsibility for the non-covered service provided specific requirements are met and are placed in the Member's treatment record. The Member must sign a written form that explains the type of services that are not covered by Medicaid due to lack of medical necessity, details the amount of money the dental provider will charge the member for the service(s), and confirms that the Member understands that he or she is consenting to paying for the services before services are rendered.

Member Responsibilities

- Members should monitor their dental utilization throughout the year, including reviewing notifications regarding accumulated benefit usage and through the CTDHP secure Member Portal
- Members are expected to discuss treatment priorities and sequencing with their dental provider to ensure the most clinically appropriate services are completed within the benefit structure
- When clinical needs may exceed the annual maximum, members should understand that additional services may be covered only when approved as medically necessary through the prior authorization process
- Members are encouraged to maintain preventive care, keep scheduled appointments, and actively participate in treatment planning to support disease management and avoid more extensive treatment needs

Coverage Guidance on Commonly Performed Services that Require Prior-Authorization

Identified below are coverage and authorization submission guidance on the more commonly performed services. To find additional coverage guidance please go to the Provider Benefit Resource Tool at https://ctdhp.org/provider-benefit-resource/.

ENDODONTIC THERAPY

Coverage Conditions	Endodontic services are covered for adults (over the age of twenty-one (21)) and children ages ages zero through twenty (0-20) if the following conditions are met: • The prognosis for the treated tooth and dentition is favorable • Not more than 25% periodontal bone loss • There is no active periodontal disease • Adequate tooth structure remains to restore the tooth to form and function • Not covered on primary teeth **Adults (over the age of twenty-one (21)):** The tooth to be treated must be in occlusion with a natural tooth or the opposing tooth will be immediately restored or replaced with an artificial tooth
Applicable Codes	• D3310 - anterior • D3320 - premolar • D3330 - molar
Frequency	• Once Per Tooth Per Lifetime
Authorization Guidance	Prior Authorization or Post Procedure Review is required for all providers except Endodontists. Supporting documentation required for submission includes: • Complete charting of the member's dentition • Recent (less than one (1) year) radiographs (PA + bitewing) Documentation showing prognosis and restorability that coverage guidelines have been met All documentation must be clearly labeled and dated
Other Information	In the event an emergency prior authorization is needed for endodontic therapy please contact CTDHP Provider Service Representatives at 888-445-6665 (8:00am to 5:00pm, Monday through Friday) for assistance in determining if the service will meet the state's medical services regulations and policy. Please have the following information ready: • Provider Name and NPI of the billing entity and performing provider • Member's Name • Member Date of Birth and Medicaid ID • Proposed procedure to be performed • Proposed treatment plan • Presence or absence of the Member's teeth

ENDODONTIC THERAPY RETREATMENT

Coverage Conditions	Retreatment of previous root canal therapy is covered for an adult or child as long as the following conditions are met: • The prognosis for the treated tooth and dentition is favorable • Not more than 25% bone loss • There is no active periodontal disease • Adequate tooth structure remains to restore the tooth to form and function **Adults (over the age of twenty-one (21)):** The tooth to be treated must be in occlusion with a natural tooth or the opposing tooth will be immediately restored or replaced with an artificial tooth.
Applicable Codes	• D3346 - anterior • D3347 - premolar • D3348 - molar
Frequency	• Once Per Tooth Per Lifetime
Authorization Guidance	Submission must include completed charting/documentation confirmation of the following: • No active periodontal disease • 75% bone support and tooth is restorable • Diagnostic periapical radiograph or tomosynthesis showing evidence of: - Periapical pathology - Qualify conditions (e.g broken instrument, missing canal, overfill, etc) - Periapical Radiolucency - Missed Canals - Poorly Obturated Canals - Exposed Gutta Percha - Inadequate Prior Restoration - Complex Morphology - Surgically Inaccessible Roots

CROWNS

Coverage Conditions	Crowns are a covered service when the following conditions are met: • For members under the age of twenty-one (21) and at least sixteen (16) years of age where root formation is complete. Not covered on primary teeth • For adult members (over the age of twenty-one (21)) where the crown is used to restore a tooth where there is excessive loss of tooth structure due to caries or trauma, or root canal therapy has been performed, and the prognosis is favorable. The tooth to be treated must be in occlusion with a natural tooth, or the opposing tooth will be immediately restored or replaced with an artificial tooth • For adult members (over the age of twenty-one (21)) with bilaterally missing teeth in the same arch are not eligible for multiple, single (1) crowns to restore deteriorated dentition unless the crowns will form the last remaining abutment tooth/teeth in an arch for partial denture placement

Coverage Conditions (continued)	Tooth must have good prognosis and be restorable. Replacement of an existing artificial crown shall be covered only when the crown becomes defective in the permanent teeth after a ten-year (10-year) period has lapsed. Replacement of a lost crown on a permanent tooth will be reimbursed after a three-year (3-year) period has lapsed by the same provider. **Crown types covered include:** • Cast Crowns on all permanent teeth • Ceramic/Zirconia crowns on all primary and permanent teeth • Milled Crowns which follow the regulations for crowns on permanent teeth • Porcelain fused to metal crowns on all permanent teeth • Stainless-steel crowns on primary teeth or permanent teeth when the root apices are open or if the tooth is nearing exfoliation, there is remaining root structure which warrants the placement of a stainless-steal crown • Aesthetic coated stainless-steel crowns for primary and permanent teeth 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. Submission for fillers to smooth out irregularities in the tooth preparation are not a separate benefit because they are considered an integral part of the crown procedure and do not constitute a separate billable service.
Applicable Codes	• D2751 - premolars and anterior teeth • D2791 - first and second molars
Frequency	One (1) per ten (10) years.
Authorization Guidance	**Providers Subject to Authorization Requirements:** • **D2751:** Endodontist, Oral & Maxillofacial Pathologist, Periodontist, Prosthodontist (for member under age 21), Dental Anesthesiologist, Pediatric Dentist, General Dentist, Oral Surgeon, Orthodontist, Hospital and Free-Standing Clinic, FQHC • **D2791:** Endodontist, Oral & Maxillofacial Pathologist, Periodontist, Prosthodontist (for member under age 21), Dental Anesthesiologist, Pediatric Dentist, General Dentist, Public Health Dentist, Oral Surgeon, Orthodontist, Hospital and Free-Standing Clinic, FQHC **Documentation submitted must include:** • Complete charting and (less than one (1) year) recent radiographs consisting of a periapical and minimum one (1) bitewing of the tooth in questions • Recent (less than one (1) year) radiographs consisting of a periapical and a minimum one (1) bitewing of tooth in question

Other Information	Replacement of an existing artificial crown is covered only when the crown becomes defective in the permanent teeth after a ten-year period has lapsed Replacement of a stainless-steel crown or zirconia crown in the primary dentition is covered if the crown is lost and only if the tooth is not nearing exfoliation and there is remaining root structure which warrants replacement of the crown Replacement of a lost crown on a permanent tooth will be reimbursed after a three-year period has lapsed by the same provider

RADIOGRAPHS

Coverage Conditions	**Intraoral Periapical:** • Will not be covered for routine screening services for children ages zero through twenty (0-20) or adults (over the age of twenty-one (21)); • Will not be covered on an individual basis when ten or more periapical images are taken over multiple visits to constitute a complete series; • Will not be covered if two or more periapical or tomosynthesis image are taken on the same day, the first periapical shall be coded as the first periapical image and subsequent periapical images shall be coded as additional periapical images regardless of the tooth number by each provider **Bitewings:** One set of horizontal or vertical, intraoral or extraoral bitewing images or tomosynthesis images for member in a twelve-month (12-month) period as follows: • Bitewing or tomosynthesis images are included in the complete mouth or Tomosynthesis series and shall not be reimbursed separately from a complete mouth or tomosynthesis series or where a panoramic radiograph is substituted for a complete mouth or tomosynthesis series: • No more than four bitewings or tomosynthesis images may be taken per visit; and • Additional bitewing or tomosynthesis images may be prior authorized for member who have had a diagnosis of white spot lesions or interproximal decay within the previous twelve months that require monitoring **Panoramic:** • A panoramic image one time per three-year period per member for members nine years of age and over. The panoramic radiograph may be taken with tomosynthesis bitewing diagnostic imaging in lieu of the complete series and must have the right and left sides clearly identified

Coverage Conditions (continued)	**Cone Beam:** • One cone beam image when medically necessary to determine the extent of disease states such as cysts, tumors or when major traumatic events have occurred within the upper or lower jaw or oro-facial structures. Additional cone beam imaging may be prior authorized for members who have dento-facial anomalies for any reason or have undergone repair and require monitoring • One cone beam maxillae or mandible image for multi-rooted premolar and molar teeth undergoing endodontic therapy limited to one time every three years with prior authorization if the tooth to be treated is eligible for endodontic therapy (includes root canal therapy, retreatment of previously endodontically treated teeth and apicoectomies) and can be restored with an exception being made if a root fracture is discovered
Applicable Codes	**Intraoral:** • D0210 - Complete Full Mouth Series • D0220 - Periapical 1st Film • D0230 - Each Additional Film • D0240 - Occlusal **Bitewings:** • D0270 - Single • D0272 - Two • D0274 - Four **Panoramic:** • D0330 **Cone Beam:** • D0364 -D0368 **Tomosynthesis Images:** • D0372 - Complete • D0373 - Bitewing • D0374 - Periapical

Frequency Authorization Guidance	**Intraoral Complete Series:** One (1) complete mouth series or a panoramic film plus bitewing(s) one (1) time per three-year (3) period for members over the age of nine (9) **Periapical:** One (1) initial periapical and up to three (3) additional per member or four (4) images in total per member **Intraoral Occlusal:** One (1) time per arch every two (2) years **Bitewings:** One (1) procedure per member per calendar year. No more than four bitewings per visit. **Panoramic:** One (1) time per three-year (3) period per member **Cone Beam:** One (1) when medically necessary to determine disease state. One (1) maxilla or mandible image for multi-rooted premolar and molar teeth undergoing covered endodontic therapy (including retreatment) every three (3) years Prior Authorization required for D0210 by provider type: Endodontist, Oral & Maxillofacial Pathologist, Dental Anesthesiologist, Oral Surgeon, Orthodontist, Public Health Dentist Prior Authorization required for D0220, D0230 by provider type: Dental Anesthesiologist Prior Authorization required for D0270, D0272, D0274 by provider type: Endodontist, Oral & Maxillofacial Pathologist, Dental Anesthesiologist, Orthodontist Prior Authorization required for D0330 by provider type if the member is over the age of 21: Endodontist, Periodontist, Prosthodontist, Dental Anesthesiologist, Pediatric Dentist, General Dentist, Public Health Dentist Prior Authorization required for DO330 by provider type only: Orthodontist Prior Authorization required for D0364, D0365, D0366, D0367, D0368 by provider type: Endodontist, Oral & Maxillofacial Pathologist, Periodontist, Prosthodontist, Dental Anesthesiologist, Pediatric Dentist, General Dentist, Oral Surgeon, Orthodontist, Dental Hygienist, Public Health Dentist, Hospital and Free-Standing Clinic, FQHC
Other Information	The potential pathological condition for taking any periapical radiograph on a young child must be clearly documented in the member's chart. Bitewings: Additional images beyond frequency timing may be authorized if member has a diagnosis of white spot lesions or interproximal decay within the previous twelve months. 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. 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. 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.

PERIODONTAL THERAPY

Coverage Conditions	Periodontal Therapy services are covered for adults (over the age of twenty-one (21)) and children ages zero through twenty (0-20) if the following conditions are met: • Periodontal Therapy for children ages zero through twenty (0-20) is a covered service under EPSDT guidelines • For adults (over the age of twenty-one (21)), treatable periodontal disease regardless of whether surgical intervention may be recommended in the future • For adults (over the age of twenty-one (21)), a diagnosis of a co-morbid condition(s) that affect systemic health conditions from the following list: - Acute rheumatic endocarditis - Acute and subacute endocarditis - Congenital malformations of aortic and mitral valves - Congenital malformations of pulmonary and tricuspid valves - Nonrheumatic tricuspid valve disorders - Nonrheumatic pulmonary valve disorders - Presence of prosthetic heart valve - Presence of xenogeneic heart valve - Presence of other heart-valve replacement(s) - Rheumatic aortic valve diseases - Rheumatic diseases of the endocardium and valve(s) - Rheumatic mitral valve diseases - Rheumatic tricuspid valve diseases - Viral endocarditis - Endocarditis in systemic lupus

Coverage Conditions (continued)	- Erythematosus - Nonrheumatic aortic valve disorders - Encounter for anti-neoplastic agents including ionizing pellets placed in the head, neck or thorax - Personal history of antineoplastic chemotherapy - Head, neck and/or thorax radiation therapy - Long term (current) use of chemotherapeutic agents - Epilepsy/Seizure disorder with a current or past history of Dilantin/Phenytoin use and a history of current and documented clinical evidence of Gingival Hyperplasia - Diabetes Mellitus Type I - Diabetes Mellitus Type II - End Stage Renal Disease Organ Transplant – Candidate or Post–status: - Heart Transplant - Hepatobiliary Transplant - Intestinal Transplant - Pulmonary Transplant - Kidney Transplant - Stem Cell Transplant
Applicable Codes	• D0180 – Comprehensive Periodontal Evaluation • D4355 - Full Mouth Debridement • D4341/D4342 - Scaling and Root Planing • D4910 – Periodontal Maintenance
Frequency	D0180 Comprehensive Periodontal Evaluation • One (1) Comprehensive Periodontal Evaluation per adult member per lifetime. • HUSKY Health members under age 21 may qualify for additional evaluations under EPSDT guidelines. PA required for additional evaluations D4355 Full Mouth Debridement • One (1) time per calendar year per adult member - Additional Debridement services may be requested for reasons of medical necessity for adults (over the age of twenty-one (21)) who have special healthcare needs • HUSKY Health members under the age of 21 years may qualify for additional debridement under EPSDT guidelines • Is not reimbursable if performed in conjunction with D0180, D4341, or D4342 on the same date D4341/D4342 Scaling and Root Planing (SRP) • Limited to no more than two (2) combinations per quadrant per visit • D4341 is limited to 4 Quadrants per 36- Month Period • D4342 is limited to no more than the equivalent to 4 quadrants per 36-month period

Frequency (continued)	**D4910 Periodontal Maintenance** • Limited to two (2) times in any 12-month period for both adults (over the age of twenty-one (21)) and children ages zero through twenty (0-20) • Cannot be performed in conjunction with D0180, D4341, or D4342
Authorization Guidance	Periodontal Treatment requires Prior Authorization. The following documents are required in the submission: • Comprehensive Phased Treatment Plan • Comprehensive Periodontal Evaluation charting and/or narrative that includes: - Probing for all six (6) aspects for each tooth - Condition of the gingivae and oral tissues (if bleeding is present or not) - Tooth Mobility Grading Scores - Plaque Scores - Description of the location and severity of both supra- and subgingival calculus deposits - Recession and attachment loss (if present) - All oral disease states and diagnoses - Medical history including alcohol consumption, illicit drug use, drugs that cause xerostomia or gingival hyperplasia, history of tobacco (vaping, chewing, smoking) and cannabis use. • The most recent Complete Mouth Imaging Series no older than 36 months supplemented with current bitewing imaging and/or periapical imaging or photographs showing quadrants or sites with periodontal involvement - Assessment of the patient that demonstrates the patient is motivated to pursue and maintain periodontal treatment and a copy of the Periodontal Treatment Pledge and Action Plan completed and signed. The Periodontal Treatment Pledge and Action Plan can be found at https://ctdhp.org/wp-content/uploads/2023/12/Periodontal-Treatment-Oral-Health-Action-Plan.pdf Prior Authorization required for D4341, D4342, D4355, D4910 by provider type: Periodontist, Prosthodontist, Pediatric Dentist, General Dentist, Public Health Dentist, Hospital and Free-Standing Clinic, FQHC
Other Information	**D0180 Comprehensive Periodontal Evaluation** • A D0180 evaluation should include a comprehensive dental examination, probing of all six (6) aspects of each tooth, periodontal charting, and a review of the patient's medical history. • D0180 cannot be billed on the same date of services for D0150 Comprehensive Oral Evaluation • May be billed independently; however, D4355 cannot be billed on the same date of service as D0180 - This restriction applies only to the same day combination of these two codes • D0180 should be used only when your office or clinic will be providing the periodontal scaling and root planning services. If the member must go to another office or clinic to receive the periodontal treatment, the D0180 reimbursement will be recouped **D4355 Full Mouth Debridement** • When D4355 is performed, no other periodontal codes (including D0180, or D4341/D4342) may be billed on that same date of service D4341/D4342 Scaling and Root Planing (SRP) • D4341 The quadrant receiving the service must be identified • D4342 The tooth number(s) must be submitted in addition to the quadrant All FQHCs are required to submit the same documentation for members. One (1) unit of each periodontal service will be authorized for each encounter. Procedures for debridement and scaling and root planing should be performed as one (1) debridement encounter and one (1) encounter for each perodontal scaling and root planing treatment

Other Information (continued)	Providers are required to enter an appropriate ICD-10 Diagnosis code for the Member's condition on the submission claim form. The claim form can accommodate up to four diagnosis codes. Primary diagnosis codes should be used in 34"A". Only a limited set of codes are accepted currently: **ICD 10 CODES** **1. Periodontitis** **a.** K05.211 - Aggressive periodontitis, localized, slight **b.** K05.212 - Aggressive periodontitis, localized, moderate **c.** K05.213 - Aggressive periodontitis, localized, severe **d.** K05.221 - Aggressive periodontitis, generalized, slight **e.** K05.222 - Aggressive periodontitis, generalized, moderate **f.** K05.223 - Aggressive periodontitis, generalized, severe **g.** K05.311 - Chronic periodontitis, localized, slight **h.** K05.312 - Chronic periodontitis, localized, moderate **i.** K05.313 - Chronic periodontitis, localized, severe **j.** K05.314 – Periodontitis **2. Caries - Risk Factors** **a.** Z91.841 - caries – low caries risk **b.** Z53.09 - caries – moderate risk **c.** Z91.843 - caries – high risk **3. Tooth wear** **a.** K03.0 – Excessive attrition of teeth **b.** K03.1 - Attrition of teeth **c.** K03.2 - Erosion of teeth **4. Gingivitis** **a.** K05.00 - Acute gingivitis, plaque induced **b.** K05.01- Acute gingivitis, non – plaque induced **c.** K05.10 - Chronic gingivitis, plaque induced **d.** K05.11 - Chronic gingivitis, plaque induced **5. Gingival Recession** **e.** K06.011 – Localized gingival recession, minimal **a.** K06.12 – Localized gingival recession, moderate **b.** K06.13 - Localized gingival recession, severe **c.** K06.021 - Generalized gingival recession, minimal **d.** K06.022 - Generalized gingival recession, moderate **e.** K06.22 - Generalized gingival recession, severe

Other Information (continued)	6. **K066- Other Gingival Conditions** a. K06.1 – Generalized enlargement b. K06.2 – Gingival and edentulous alveolar ridge regions associated with trauma c. K06.3 – Horizontal alveolar bone loss 7. **Substance Abuse** a. F10.10 - Alcohol use; uncomplicated b. F10.11 - Alcohol abuse; in remission c. F10.19 - Alcohol abuse with unspecified alcohol – induced disorder d. F10.29 - Alcohol intoxication; unspecified e. Z71.6 - Tobacco use counseling provided f. Z72.0 - Nicotine dependence, unspecified, uncomplicated g. F17.200 - Nicotine dependence, cigarettes uncomplicated h. F17.210 - Nicotine dependence, chewing tobacco, complicated i. F10.290 - Nicotine dependence, other tobacco products, unspecified 8. **Personal History** a. F41.9 - anxiety disorder, unspecified b. R45.0 - Nervousness c. R92.9 - Feeding disorder of newborn, unspecified d. Z91.19 - Patient's noncompliance with medical treatment or regimen e. Z91.89 - Other personal risk factors, otherwise non-specified f. Z92.3 - Personal history of radiation unspecified g. Z79.01- Long term (current) use of anticoagulants h. Z79.82 - Long term use of aspirin i. Z71.83 - Long term use of bisphosphonate therapy j. Z79.891- Long term use (current) of opioid k. K00.9 - Disorders of tooth development and /or eruption, unspecified (i.e. Disorders of Odontogenesis NOS)

DENTURES

Coverage Conditions	Key Definition: **Minimally functional occlusion** is defined as having a minimum four "adjacent" posterior teeth in occlusion on each side (Right **AND** Left) of the mouth. Complete Dentures are covered when the following conditions are met: • Member is edentulous • Member will use and benefit from dentures on a daily basis • Member or caregiver has capacity to care for denture • Adequate jawbone structure to support the prosthesis • Sufficient healthy gum tissue

Coverage Conditions (continued)	**Removable Partial Dentures are covered when the following conditions are met:** • If less than 4 adjacent posterior teeth occlude on either or both sides of the mouth. Or, • If any anterior teeth are missing. And, • The proposed abutment teeth have a good prognosis • **Note:** Adjacent teeth are teeth which have no space between them i.e.: 2 bicuspids occluding with 2 bicuspids, second bicuspid and first molar occluding with same, first and second molars occluding with same **Fixed Acid Etched Partial Dentures are covered when the following conditions are met:** • The member is under age 21 • Have a congenitally missing or traumatic loss of anterior teeth • The member's abutment teeth are sound • Member can maintain oral hygiene, which includes brushing and flossing daily • Member must have all decay treated and free from gingivitis or periodontal disease. • **Note:** Acid etch or "Maryland" bridgework **Implant Supported Overdentures are covered when the following conditions are met:** • There is not enough alveolar ridge to support a denture • In specific cases: - Facial trauma or a severe infection, that results in the removal of: • necrotic bone; • or resection due to tumors and there is missing bone, and the implants are used to restore occlusion or support the facial prosthesis • May be covered for members under the age of twenty-one for missing anterior teeth based on medical necessity
Applicable Codes	• D5110/D5120 - Complete Dentures • D5211-D5214 - Removable Partial • D6241/D6545 - Fixed Acid Etched Partial Dentures – Children ages zero through twenty (0-20) • D611-D6113; D6191/D6192 - Implant Supported Overdentures • D5710/D570; D5720/D5721 - Rebasing • D5730-D565 - Relining
Frequency	• Complete and Partial Dentures: Once per every seven (7) years • Rebasing and Relining: Covered once per every two (2) year period. A rebase/reline may be allowed earlier if teeth were extracted within 6 months of denture prosthesis delivery.
Other Information	Members must be provided the "Caring for Your Dentures" brochure and initial/sign the "Member Acknowledgement of Receipt of Denture(s) and Description of the Policies for Replacement form downloadable from **https://ctdhp.org/resources/**. The original signed copy must be entered in the Member's chart. There is a seven (7) year frequency limitation on full and partial dentures. All denture replacements within the seven-year frequency limitation require prior authorization.

Other Information (continued)	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 (1) 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 **Denture labeling will be reimbursed for Members who reside in Long-Term Care Facilities only.**

ANESTHESIA

Coverage Conditions	**Deep Sedation & Moderate Intravenous Sedation is covered when the following conditions are met:** • Children ages zero through twenty (0-20) or members who have a behavioral or cognitive condition which prevents them from receiving care safely • For use with all members undergoing in office oral surgical procedure(s) where sedation: - is required to perform the procedure **OR** - is required for the extraction of five or more teeth **OR** - is required for removal of a tooth which fails to become adequately anesthetized using local anesthesia **OR** - is required for the extraction of third molars if removal of the third molars is medically necessary and all four (4) third molars are being removed during one procedure **General Anesthesia with Advanced Airway is covered when the following conditions are met:** • The service can only be performed by an Oral and Maxillofacial Surgeon or Dental Anesthesiologist who has an active permit to administer dental anesthesia/deep sedation issued by the Connecticut Department of Public Health (DPH) and in accordance with DPH's regulations on the administration and use of anesthesia and sedation in dentistry • Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient Services are considered complete when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room **Administration of Nitrous Oxide is covered when the following conditions are met:** • Member (any age) who has a diagnosis of a documented anxiety, behavioral health, cognitive disorder, or medical condition(s) which supports the need for behavioral management related to the dental procedures to be delivered • The techniques are employed in conjunction with delivery of dental services to individuals to help facilitate a safe environment and reduce dental anxiety **Moderate Sedation Non-IV Parenteral is covered when the following conditions are met:** • The service can only be performed by an Oral and Maxillofacial Surgeon or Dental Anesthesiologist who has an active permit to administer dental anesthesia/deep sedation issued by the Connecticut Department of Public Health (DPH) and in accordance with DPH's regulations on the administration and use of anesthesia and sedation in dentistry • Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient • Services are considered complete when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room
Applicable Codes	• D9222/D9223 - Deep Sedation • D9239/D9243 - Moderate Intravenous Sedation • D9224/D9225 - General Anesthesia with Advanced Airway • D9230 - Nitrous Oxide • D9246/D9247 - Non-Intravenous Parenteral
Frequency	D9222/D9223, D9239/D9243, D9246/D9247: Limited to eight (8) units per visit in agreement with sedation logs.

Authorization Guidance	**Deep Sedation and Moderate Intravenous Sedation** **A Prior Authorization or Post Procedure Review is required for all dental providers except pediatric dentists, oral surgeons, and dental anesthesiologists. Documentation required for submission includes:** • 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 behavioral or cognitive conditions that prevents the patient from receiving care safely • Anesthesia flow sheet containing the pharmacologic agent, dose and duration of administration, and • Vital signs must be maintained in the patient's record General Anesthesia with Advanced Airway and Non-Intravenous Parenteral Sedation can only be performed by Oral and Maxillofacial Surgeon or Dental Anesthesiologist who has an active permit to administer dental anesthesia/deep sedation issued by the Connecticut Department of Public Health (DPH) and in accordance with DPH's regulations on the administration and use of anesthesia and sedation in dentistry. **Nitrous Oxide** **Prior Authorization or Post Procedure Review is required for all providers except Dental Anesthesiologist, Pediatric Dentists, and Oral Surgeons. Documentation required for Submission includes:** • A brief description of the member's anxiety, illness or disability including the diagnostic code; • If the member does not have a cognitive disability, then a description of the anxiety and behaviors warranting behavior management; and • A letter from the member's attending physician certifying the medical or behavioral diagnosis or if the member is a member of the Department of Developmental Services, the member's certificate will meet the documentation requirements • Vital signs must be maintained in the patient's record

ADULT (OVER AGE 21) PERIODIC EXAMINATION AND PROPHYLAXIS

Coverage Conditions	Coverage for adult periodic exam and prophylaxis is limited to one time per calendar year. If the adult member has exceeded its limit in the calendar year and has a chronic medical or dental condition that warrants these dental services more frequently than the defined limitations for each procedure, an additional service may be requested. CTDHP has automated the authorization of the second annual periodic exam and prophylaxis for adult members with documented (via presence of medical claim) disease conditions identified below. The Prior Authorization will be generated for the recall visit the month after the provider submits a claim for the first exam and prophy. • 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
Applicable Codes	• D0120 -Periodic Oral Evaluation • D1110 – Prophylaxis
Frequency	One time per calendar year
Authorization Guidance	Submit narrative describing need for additional services based on medical necessity.

ORTHODONTIC

Coverage Conditions	• **Orthodontic services are covered when the following conditions are met:** • The Member is under age 21 **AND** • The Member obtains 26 or more points on a correctly scored Malocclusion Severity Assessment. **OR** • The Member 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** • Eligible HUSKY Health member, who has one of the following congenital conditions: - Cleft palate or a history of a treated bony cleft palate - Impacted anterior teeth (incisors and/or canines) - Congenitally missing teeth that will be prosthetically replaced (excluding premolars). - Deep impinging overbite with soft tissue impaction causing severe tissue damage which is demonstrated by laceration or attachment loss - Anterior or posterior crossbite, or both, of three or more teeth per arch - Overjet greater than 9mm or a reverse overjet of 3.5 mm - When the mandible or maxillae, or both, or when the dentition are significantly affected by a congenital or developmental disorder, such as a craniofacial anomaly, trauma, or pathology - Syndromic craniofacial condition or conditions which affect the development of teeth • If the member 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 • For HUSKY Health members 21 years and older coverage is only considered when there are untreated congenital conditions, facial forms of cancer or trauma, or surgical facial reconstruction is required
Applicable Codes	• D8080 – Comprehensive Orthodontic Treatment • D8670 - Periodic Orthodontic Treatment Visits
Frequency	For HUSKY A, C, D, and Covered CT Members services are limited to one orthodontic case per lifetime. For HUSKY B members there are no lifetime limits.
Authorization Guidance	Prior Authorization is required for HUSKY A, C, D Members. Although prior authorization is not required for HUSKY B Members, providers are strongly encouraged to complete and retain documentation demonstrating criteria has been met. Authorization request submissions must include: • The standard ADA or similar claim form detailing: - Member full name - Member Medicaid ID Number - 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 - Usual and customary fee(s) - Any other pertinent insurance coverage information

Authorization Guidance (continued)	
	• Properly trimmed study models • A properly completed and scored Salzmann Malocclusion Severity Assessment form* • A panoramic x-ray • Additional documentation from referring general dentists, attestation from licensed mental health professional, or a statement that no other documentation was presented • 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 Submissions submitted for review without complete documentation will be returned to the submitting office. Authorization requests can be submitted electronically via the CTDHP Provider Portal (See link and instructions in Chapter 1) or paper/hard copy can be mailed to: Orthodontic Case Review C/O BeneCare Dental Plans 195 Scott Swamp Road, Suite 101 Farmington, CT 06032 **Section E Intra Arch Deviation** • Only the four (4) 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 (4) 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

Authorization Guidance (Continued)	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.
Other Information	**Case Processing and Payment** • Monthly remittances for 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 • Total orthodontic case fees for HUSKY A, C, D or Covered CT are $3,210.00 and will be comprised of the following: - One (1) initial payment for Comprehensive Orthodontic Treatment (D8080) of $584.3 - 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). The HUSKY B member (or responsible party) must sign a financial agreement with the enrolled dental provider acknowledging that the HUSKY B member or responsible party accepts financial responsibility for any costs exceeding the HUSKY B allowance **Common Eligibility Circumstances** • Prior approval is required for HUSKY A, C, D and Covered CT cases that were already under active treatment at the time the member became eligible. The Member must have met the current standards outlined in the regulation before having commenced with their orthodontic therapy. Members are responsible for contacting their previous orthodontist and having their records transferred • In circumstances where a HUSKY B Member becomes eligible under HUSKY A, C, D, or Covered CT 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 • If a member becomes eligible under HUSKY A, C, D or Covered CT 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 member 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

CHAPTER 6

Connecticut Dental Health Partnership Services and Supports to Providers

The Connecticut Dental Health Partnership (CTDHP) offers a comprehensive suite of services and supports designed to assist dental providers participating in the HUSKY Health Dental Program. These services are intended to promote efficient practice operations, support clinical decision-making, facilitate timely access to care for members, and strengthen collaboration across providers, members, and community partners. The following sections outline the key CTDHP teams, resources, and processes available to support providers throughout their participation in the program.

Professional Relations and Network Development

The Professional Relations and Network Development team serves as the liaison between enrolled dental providers and the Department of Social Services and its other administrative entities, working to ensure participation in the HUSKY Health Dental Program is efficient, transparent, and well supported. The team provides technical assistance throughout the provider lifecycle, from recruitment, to supporting the contracting, credentialing, and recredentialing processes administered by Gainwell Technologies, while helping providers navigate program requirements, policies, and administrative processes.

The team also delivers ongoing education and practice support through provider training, in-person consultations, and telephone assistance. They provide guidance on benefit coverage, prior authorization submissions, and policy interpretation, assist with member-specific questions and complex care scenarios, and connect providers with oral health navigation resources when additional member support is needed. Through regular communications, including provider newsletters, website updates, and educational materials, the team ensures providers remain informed of changes to Medicaid policies and HUSKY Health Dental Program requirements.

Support includes:

- Assisting providers with the contracting, credentialing and recredentialing process administered by Gainwell Technologies
- Providing guidance on coverage, authorization submissions, and policy interpretation through in-person meetings, trainings, and ongoing telephone support
- Assisting with member-specific questions and scenarios, and connecting members to oral health navigation services and care
- Communicating updates and changes related to the Medicaid program in general, and the HUSKY Dental Program specifically, through e-newsletters, website updates, and other communication channels

To request a meeting, training, or need for support please contact us at **855-CT-DENTAL (855-283-3682)**

Authorization Services and Provider Support

The Authorization Services Team oversees the authorization process and connects with providers to support them in:

- Receiving, processing, and managing routine and emergency authorization requests
- Performing administrative reviews of authorization submissions to confirm inclusion of required data elements, documentation, proper labeling, and compliance with frequency limits and exclusions
- Communicating with providers regarding administratively pended or denied requests that do not meet coverage criteria due to frequency limits or other non-clinical requirements (e.g., age restrictions)
- Supporting and facilitating the provider administrative and clinical appeal processes

CTDHP dental consultants review authorization requests to determine if the service is medically and dentally necessary, clinically appropriate given the member's current circumstances and prognosis, are the least costly treatment to effectively and comprehensively treat all diagnosed pathology and restore the Member's dentition and function. They can support providers in conducting Peer to Peer Review.

For support, please contact us at **888-445-6665**

Member Appeals

The Appeals Team guides members through the appeal and administrative hearing process following a denied dental service, coordinating secondary reviews by CTDHP dental and orthodontic consultants, preparing cases for Department of Social Services Office of Legal Counsel, Regulations and Administrative hearings, educating members on the hearing process, arranging interpreter services when needed, and developing hearing summaries and exhibits. These activities help ensure authorization decisions are reviewed consistently, transparently, and in accordance with Medicaid regulations and Members' Rights.

KEY FOCUS AREAS

- **Member Appeals Support** Educate and assist HUSKY Health members in understanding their appeal rights, hearing process, and available resources.
- **Appeals Administration and Regulatory Compliance** Coordinate and manage appeal activities to ensure all administrative requirements, timelines, and regulatory standards are met in accordance with Medicaid regulations and Members' Rights.
- **Hearing Coordination and Case Preparation** Prepare comprehensive hearing summaries, exhibits, and supporting documentation; coordinate clinical consultant participation, interpreter services, and hearing logistics to facilitate efficient and effective administrative hearings.

Contact us Monday - Friday 8am-5pm
Translation Services Available
855-CT-DENTAL (855-283-3682)

Member Care and Community Connection Teams

A distinguishing component of the Connecticut Dental Health Partnership (CTDHP) is its statewide Member Care and Community Connections Team. Services for HUSKY Health and Covered CT members are focused on three core areas: Oral Health Navigation, Community Engagement, and Constituent Services Call Center.

Oral Health Navigation

Oral Health Navigation is a collaborative, member-centered process involving the member, an Oral Health Navigator, and dental provider(s). The process focuses on assessing member needs, developing care plans to enable completion of dental treatment plans, and reducing or eliminating complex barriers to care. Oral Health Navigation connects members to services that address acute oral health needs while supporting the establishment of routine and preventive oral health care.

Complex barriers may include medical, behavioral health, or social factors that limit a member's ability to access or complete dental treatment. Acute oral health needs are identified collaboratively by the member and dental provider and are informed by the member's reported experience, the provider's treatment plan, and applicable HUSKY Dental Plan benefits.

Oral Health Navigation is a longitudinal model comparable to medical care management and emphasizes coordination of resources, education, and interventions to help members achieve their oral health goals.

Providers can refer Members to the Oral Health Navigation Team at any time and commonly refer Members who:

- Frequently do not show to appointments
- Exhibit or disclose complex unmet medical or behavioral health needs
- Need further support to reduce anxiety, phobia, or trauma related behaviors towards dental providers
- Need further support in oral health literacy or understanding home care instructions
- Providers express concern that members may experience gaps in care and not complete dental treatment

Members can be referred through CTDHP's secure referral portal at **ctdhp.org** or via the Unite Us referral platform (Unite Connecticut). Requests may also be made by contacting the call center at **855-CT-DENTAL (855-283-3682)**

Constituent Services Call Center

The Constituent Services Call Center serves as the primary point of contact and front door to CT Dental Health Partnership for HUSKY Health and Covered Connecticut members, dental providers, community partners, advocates, and stakeholders. Every interaction is an opportunity to improve access to care, build trust, and ensure members receive timely, accurate, and compassionate service.

Through an integrated customer service model, the department combines expertise in member eligibility, dental benefits, claims support, provider participation, and prior authorizations to maximize first contact resolution, minimize unnecessary transfers, and deliver a seamless customer experience. Representatives not only answer questions but also educate members about their benefits, help them navigate the dental system, and connect them to the services and resources they need.

The Constituent Service Call Center plays a critical role in advancing CTDHP's mission by helping members establish and maintain a dental home while identifying and addressing barriers to care. The department collaborates closely with Oral Health Navigation, Provider Relations, Community Engagement to coordinate services and resolve complex member issues. In addition, member feedback and call trends provide valuable operational insights that help inform quality improvement initiatives, policy discussions, and program enhancements.

Assistance is provided in both English and Spanish, with interpretation services available for members who speak additional languages. After normal business hours, callers have access to voicemail for follow-up by the Member Services team or may connect directly with United Way 211 for immediate assistance when appropriate, ensuring members have access to resources beyond regular operating hours.

KEY FOCUS AREAS

- Serve as the primary point of contact for members, providers, community partners, advocates, and stakeholders
- Deliver exceptional customer service while meeting organizational performance goals for service level, call response, first contact resolution, and member satisfaction
- Assist members with eligibility and benefit questions, provider referrals, appointment scheduling, transportation assistance (when applicable), claims inquiries, and prior authorization support
- Educate members on their dental benefits and available services to help them successfully navigate the HUSKY Health Dental Program
- Assist providers in answering questions on member eligibility, authorizations, claims, and enrollment
- Coordinate with internal departments and external partners to resolve complex member and provider issues
- Promote equitable access to care through bilingual staff, interpretation services, and culturally responsive customer service

Contact us Monday - Friday 8am-5pm
Translation Services Available
855-CT-DENTAL (855-283-3682)

Community Engagement Specialists

Community Engagement Specialists design, implement, and support community-based communications and activities to increase awareness of HUSKY Health dental plan benefits and oral health literacy. Their work promotes program contact information, enhances understanding of services provided by the Connecticut Dental Health Partnership (CTDHP), and supports the distribution of oral health education to members, community partners, providers, and oral health advocates.

KEY FOCUS AREAS

- Engage HUSKY members within their communities to promote the HUSKY Dental Plan and improve oral health literacy
- Develop and sustain local partnerships to advance oral health initiatives
- Represent the HUSKY Dental Program at community events, stakeholder meetings, and educational forums to expand program visibility and strengthen partnerships

Please reach out to the Community Engagement Specialist Team in the following ways:

- **Order Materials and Supplies:** Resources Request Form - HUSKY Dental
- **Request Trainings and Participation at Events:** Training and Events - HUSKY Dental
- **Register to Become and Community Partner Today:** CTDHP
- Email Us at: **communitypartners@ctdhp.com**

CTDHP Population Health and Data Reporting

As part of its responsibility for administering the HUSKY dental plan, CTDHP collects and analyzes a broad set of data elements to support population health management. These data are used to monitor the health and adequacy of the provider network, assess HUSKY member experience, and evaluate oral health outcomes across the covered population. Collectively, these measures support continuous quality improvement, health equity monitoring, and data-informed decision-making.

CTDHP makes population-level oral health and access measures publicly available through the following reports:

- **Annual Oral Health Equity Report,** which examines disparities in oral health access and utilization across demographic and geographic populations
- **Annual Member Survey Report,** which summarizes member experience, access to care, and satisfaction with dental services
- **Appointment Availability** and **Network Status Reports,** which assess provider network capacity and access to timely care

These reports are available at: https://ctdhp.org/reports/

In addition, registered Community Partners may access CTDHP's secure, interactive **Utilization Dashboard**. This dashboard presents annual dental utilization data at the town and ZIP code level and supports population health analysis by allowing users to stratify data by race and ethnicity, primary language, gender, and age. Key measures include preventive and treatment service utilization by age cohort, as well as non-traumatic oral health–related Emergency Department utilization.

To access the Utilization Dashboard, organizations must register as a Community Partner at: https://www.ctdhp.com/cp_reg.asp

CHAPTER 7 *Frequently Asked Questions*

Billing & Claim Submission

1. *Can a provider charge a 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.

If a member is frequently missing appointments, there may be barriers occurring preventing them from accessing care. Provider can refer the Member to CTDHP Oral Health Navigation services. Members can be referred through CTDHP's secure referral portal at **ctdhp.org** or via the Unite Us referral platform (Unite Connecticut). Requests may also be made by contacting the call center at 855-CT-DENTAL (855-283-3682)

2. *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.

3. *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.

4. *How do I know if we are using the correct specialty and taxonomy designators in our claim's 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.

5. *What is the correct way to discuss and bill for a procedure where the member requests an upgrade?*

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

6. *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 member. 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.

7. Can a Provider do a free upgrade if they are not charging the Member?

Not as a general rule. The practice is strictly limited to the provision of services on the fee schedule. Although DSS regulations permit members to pay out of pocket for non-covered goods, the federal Medicaid regulations do not permit members 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 member or a third party on behalf of the member to pay the difference for a Valplast (nylon) partial denture. If an office wants to provide a service at no charge to either the member or the Medicaid Program (pro bono) they may do so.

Authorization for Services

8. How do I find which services require authorization?

There are two CTDHP tools that describe services that require authorization and identify coverage guidelines:

CTDHP Dental Fee Schedule: **https://ctdhp.org/dental-fee-schedule/pdf/**

CTDHP Provider Benefit Resource Guide: **https://ctdhp.org/provider-benefit-resource/**

Additionally, the Connecticut Medical Assistance Program Fee Schedule is the primary source document to identify which services require authorization. It can be found at **www.ctdssmap.com** from the "home" page, go to "Provider Fee Schedule Download" and choose "dental".

9. 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.

10. Once a request for prior authorization/ Post Review 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 member 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.

11. 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.

12. 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 has established an internal appeals mechanism for providers. All appeals must be submitted in writing to the above address (See Chapter 5). If a provider is not satisfied with the final determination upon exhaustion of the CTDHP internal appeals protocols, providers may avail themselves of an independent third-party review established by the Department of Social Services (DSS).

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

13. 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.

14. If a member requests services that are not Medicaid covered services, is prior authorization required?

No. Requests for prior authorization made by Members 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 Members must ensure that they have obtained written informed consent from members in advance of rendering non-Medicaid covered services. The consent must contain laymen language written at the seventh-grade level stating the member understands and accepts responsibility for payment for the rendered non-Medicaid covered services prior to delivery of the service.

15. If a member 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 member 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 member will be responsible for payment of the service if they choose to proceed.

16. 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 fifteen (15) business days from the receipt of a fully documented and complete request for prior authorization or post procedure authorization. Missing documentation,

incomplete or illegible ADA claim forms, or other inconsistencies will result in requests being pended until the missing documentation is supplied or required information is obtained. This will delay turnaround time and more importantly patient care.

17. 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 member. 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 Member IDs, or different provider billing NPI numbers than those listed on the approval status notification will result in denial of payment.

18. 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 member 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, member's name, and member identification number and the proposed procedure to be performed. In addition, the presence or absence of the member's teeth should be included as well as the potential treatment plan for the member.

19. If the member 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.

20. If a dentist does not participate in CMAP/HUSKY, can they bill for services?

No. The provider must enroll in CMAP/HUSKY to be reimbursed for services. CTDHP works to educate HUSKY Members that in order for HUSKY Coverage they must see an enrolled provider.

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.

Continuity of Care and Member Eligibility

21. Does a continuity of care provision exist for approved multi-visit procedures that began while the member 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 member?

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 member's continued eligibility. Prior authorizations, post procedure authorizations and claim payments cannot be made for ineligible members.

22. *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 member?*

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.

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

No prior authorizations, post procedure authorizations or claims payments can be made for members whose eligibility with the CTDHP program has terminated or expired. A member's eligibility MUST be verified at each appointment. Members 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 member who becomes ineligible during a course of treatment or whose treatment plan is not completed.

Specific Services and Member Scenarios

24. *If a member is new to a provider practice, but has already had a comprehensive exam at a different practice, is the provider limited in the time required because they cannot be compensated accordingly with a comprehensive exam? (Comprehensive Exams are once per lifetime)*

The provider is responsible for providing clinically appropriate treatment to the patient. A comprehensive exam (D0150) will be approved through the PA process as long as the member 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.

25. *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 member chooses to pay for it. The office must charge the member 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 member 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. Please see Substitute House Bill No. 5127 Public Act No. 26-6, "An Act Concerning Medical Credit Cards" for more guidance on how and when a provider can charge a patient.

Although our regulations permit members to pay out of pocket for non-covered goods and services, the Medicaid program does not permit members 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 the Department of Social Services for the base denture and allow the member (or a third party on behalf of the member) to pay the difference for a higher-grade denture.

26. *Can a provider dismiss a HUSKY member from their practice for breaking appointments?*

If the Member 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.

If a Member is frequently missing appointments, there may be barriers occurring preventing them from accessing care. Providers can refer the Member to CTDHP Oral Health Navigation services. To do so, Providers can make the referral through CTDHP's secure referral portal at **ctdhp.org** or via the Unite Us referral platform (Unite Connecticut). Requests may also be made by contacting the call center at 855-CT-DENTAL (855-283-3682)

27. If a member has already had four (4) periapical films in a 12-month period and a member has an emergency visit, what should they do for x-rays?

If a member has had four (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 authorization process for approval. The authorization claim form should indicate the reason for the x-ray and must include the tooth number. A provider's office should always attempt to obtain x-rays taken in other offices and utilize previous x-rays when clinically appropriate.

28. I'm working with a member with behavioral health needs that is impacting care, what should I do?

Providers can refer Members with complex needs to CTDHP Oral Health Navigation services. To do so, Providers can make the referral through CTDHP's secure referral portal at **ctdhp.org** or via the Unite Us referral platform (Unite Connecticut). Requests may also be made by contacting the call center at 855-CT-DENTAL (855-283-3682)

29. I practice at an FQHC, what are the rules regarding "unbundling" preventive visits?

According to Public Act 22-118, 239, (b) a federally qualified health center may not provide non-emergency periodic dental services on different dates of service for the purpose of billing separate encounters. Any non-emergency periodic dental service, including, but not limited to, (1) an examination, (2) prophylaxis, and (3) radiographs, including bitewings, complete series and periapical imaging, if warranted, shall be completed in one visit. A second visit to complete any service normally included during the course of a non-emergency periodic dental visit shall not be eligible for reimbursement unless (A) medically necessary, and (B) such medical necessity is clearly documented in the patient's dental record.

State of Connecticut Dental Regulations also state that Unbundling of a group of procedures normally performed in a single visit as is the standard of care are not a covered service.

30. What can an office do if a member 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. Please contact 855-CT-DENTAL (855-283-3682) and ask for a manager to explore options.

31. 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. Providers are responsible for arranging translation supports and services per the federal regulations 1157.

Orthodontia Services

32. 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. E-models are accepted as well, see Question 35.

33. 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.

34. When scoring the Salzmann Scale 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.

35. Do you accept e-models?

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

36. 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.

37. Can a member switch orthodontists?

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

38. 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.

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

If a patient scores less than 26 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.

40. If the member 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 member 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 member who is not eligible.

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

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

42. What happens if a member starts orthodontia on HUSKY B and 6 months later becomes eligible under HUSKY A?

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

43. Who can an orthodontist call for assistance in finding an oral surgeon for a member with special needs?

Call the Connecticut Dental Health Partnership at 855-CT-DENTAL (855-283-3682) for assistance in locating an oral and maxillofacial surgeon.

44. How much does HUSKY B pay for orthodontia?

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

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

The Department of Social Services 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.

46. What if the member has qualified for treatment, brackets have been placed and the member becomes uncooperative? Can I dismiss the patient?

Yes, if the member does not adhere to the office policy they can be dismissed from 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.

CONNECTICUT
DENTAL
HEALTH PARTNERSHIP
the dental plan for
HUSKY Health