State of Connecticut
Regulation of
Department of Social Services
Concerning
Requirements for Payment of Dental Services

The Regulations of Connecticut State Agencies are amended by adding sections 17b-262-1006 to 17b-262-1018, inclusive, as follows:

(NEW) Sec. 17b-262-1006. Scope

Sections 17b-262-1006 to 17b-262-1018, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of dental services for clients who are determined eligible to receive services under Connecticut's Medicaid program pursuant to section 17b-261 of the Connecticut General Statutes.

(NEW) Sec. 17b-262-1007. Definitions

As used in section 17b-262-1006 to section 17b-262-1018, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Adjunctive dental services" means services that are not primarily dental in nature but are used in conjunction with dental therapy to support or enhance the treatment of a patient's oral health;

(2) "Adolescent dentition" means the teeth present after the loss of primary teeth, prior to the cessation of growth that would impact orthodontic treatment;

(3) "Alveoloplasty" means the surgical procedure used to reconfigure alveolar bone in the lower or upper arch;

(4) "American Dental Association" or "ADA" means the national professional association of dentists that performs public education and professional services through education, research, advocacy and the development of standards;

(5) "Anterior dentition" means the incisor and canine teeth located in the lower and upper arches;

(6) "Apexification" means the process of inducing root formation by the placement of a calcified material to encourage the continued development and closure of the root in a tooth without a fully formed root of the growing permanent tooth;

(7) "Apicoectomy" is the removal of the root end of a tooth and placement of a definitive retrograde fill material in the root end in the permanent dentition;

(8) "Appliance" means a removable or fixed dental device that is worn on the upper or lower jaw or palate for therapeutic purposes;

(9) "Behavior management" means the professional techniques or therapies used to modify the actions of a patient who is receiving dental treatment in order to deliver treatment in a safe and comfortable manner;

(10) "Best practices" means the highest quality of information available that represents the current best evidence for the treatment of a specific clinical circumstance, as is found in the larger body of dental literature;

(11) "Care coordination" means services delivered to an identified patient by a non-dental professional in order to provide assistance to the individual to gain access to oral healthcare services;

(12) "Case management" means the coordination and monitoring of treatment rendered to a

patient with a complex treatment plan or multiple medical conditions by multiple dental and medical practitioners;

(13) "CODA" means the Commission on Dental Accreditation of the American Dental Association;

(14) "Condylectomy" means the excision of the articulating surface of the mandible;

(15) "Complete mouth series" or "full mouth series" means an image of the entire oral cavity produced by radiography and consists of at least ten periapical films plus bitewings or one panoramic film plus bitewings;

(16) "Comprehensive oral examination" means an evaluation by a general dentist consisting of a thorough examination and recording of the extraoral and intraoral hard and soft tissues, evaluation for oral cancer, the evaluation and recording of the patient's medical and dental history and a general health assessment. It also includes the recording of dental caries, previously placed dental restorations, missing or unerupted teeth, existing prosthesis, periodontal conditions, hard and soft tissue anomalies, and occlusal relationships. It may require interpretation of information acquired through additional diagnostic procedures;

(17) "Connecticut Dental Health Partnership" or "CTDHP" means the dental program established pursuant to Connecticut General Statutes Section 17b-282b;

(18) "Connecticut Medical Assistance Program" or "CMAP" means all of the medical assistance programs administered by the Department pursuant to state and federal law, including, but not limited to, Medicaid, Medicaid waiver programs and the Children's Health Insurance Program;

(19) "Core build up" means a restorative procedure where a missing portion of the tooth is restored with dental filling material in order to support a crown restoration;

(20) "Cosmetic dentistry" means employing a number of different dental procedures singularly or in concert with each other in an effort to enhance the appearance of the teeth or face. Procedures performed for cosmetic reasons include, but are not limited to, crown replacement, veneer placement, bonding techniques for reasons other than the restoration of caries, mechanical reshaping of a tooth or teeth, orthodontic treatment, provision of removable dentures or implant placement and restoration;

(21) "Dental clinic" means 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;

(22) "Dental home" means the ongoing relationship between a dentist and a member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and family-centered manner. The Dental Home has a plan to provide dental services after hours in the event an emergency arises and has the ability to refer patients to appropriate dental specialists for advanced care needs;

(23) "Dental services" means any service provided by or under the direct or indirect supervision of a licensed dentist. The licensed dentist assumes the primary responsibility for all dental procedures performed under the direct or indirect supervision;

(24) "Dentist" means an individual who holds a license issued by the Department of Public Health to practice dental medicine in the State of Connecticut pursuant to section 20-106 of the Connecticut General Statutes;

(25) "Dentures" or "denture prosthesis" means artificial structures made by or under the direction of a dentist to replace some or all of the patient's teeth;

(26) "Department" or "DSS" means the Department of Social Services or any of its agents;

(27) "Early, periodic screening, diagnostic and treatment service" or "EPSDT" means the services provided in accordance with section 1905(r) of the Social Security Act, as amended from time to time;

(28) "Endodontic services" means the procedures used to treat infections or repair trauma that has

reached deep into the tooth structure, adversely affecting the pulp or periradicular structures of the tooth;

(29) "Evidence-based practice" means an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences;

(30) "Excessive loss of tooth structure" means for molar teeth - the loss of three or more tooth surfaces including two cusps; for premolar teeth – the loss of three or more tooth surfaces including one cusp; and for anterior teeth – the loss of four or more tooth surfaces including the loss of one incisal angle;

(31) "Exodontia" means the process used to remove a tooth or tooth remnants;

(32) "Fluoride treatment" means the application of any professionally prescribed product containing a professional dose of applied fluoride;

(33) "Functional Jaw Limitation" means malpositioned teeth that interfere with or limit jaw movements usually required during mastication;

(34) "Gingivectomy" means the excision or removal of gingival tissue;

(35) "Gingivoplasty" means the surgical process employed to reshape gingival tissue;

(36) "Home" or "House" means the member's residence which includes group home facilities, but does not include institutions, skilled nursing facilities, intermediate care facilities or short-term rehabilitation facilities;

(37) "Medical necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;

(38) "Medicaid" means the Connecticut Medical Assistance Program operated by the Connecticut Department of Social Services under Title XIX of the Federal Social Security Act, and related State and Federal rules and regulations;

(39) "Mobile dental clinic" means a system of care delivery where prevention based services or restorative dental services are offered in an operatory contained within the van unit or through the use of portable equipment set up at various locations;

(40) "Occlusal guards" means a removable acrylic dental appliance that is designed to minimize the effects of tooth grinding or other occlusal factors including the treatment of tempromandibular joint disease in symptomatic patients;

(41) "Oral health" means the well-being of the teeth and the gingivae and their supporting connective tissues, ligaments and bone; the hard and soft palate; the mucosal tissue lining of the mouth and throat; the tongue; the lips; the salivary glands; the muscles of mastication and facial expression; the mandible; the maxillae; the temporomandibular joints; the cranial nerves and the vascular systems that support the head and neck;

(42) "Orthognathic surgery" means the surgical correction of skeletal anomalies or malformations involving the maxilla or mandible. These malformations may be present congenitally or become evident as the individual develops;

(43) "Patient management" means techniques employed beyond basic methods of behavior modification in conjunction with the delivery of dental services to individuals who have a diagnosed cognitive impairment such as autism, cerebral palsy, hyperactivity disorder, moderate to profound developmental delay certified by the treating physician or the Department of Developmental Services;

(44) "Patient record" means the collection of written dental, medical and social documentation, diagnostic and/or laboratory tests, diagnostic imaging, images and diagnostic casts and any other information pertinent to the treatment of the patient;

(45) "Periodontal services" means the procedures used to treat diseases of the surrounding and

supporting structures of the teeth;

(46) "Permanent dentition" or "adult dentition" means the second set of teeth in the lower and upper arches; which are conventionally described using the Universal or National Numbering System as 1 through 32;

(47) "Posterior dentition "means the premolar and molar teeth located in the lower and upper arches;

(48) "Post-surgical sequela" means a pathological condition resulting from surgery to the orofacial boney structures;

(49) "Primary dentition" or "deciduous dentition" means the first set of teeth which are exfoliated and replaced by the secondary dentition of the lower and upper arches. The teeth of the primary dentition are conventionally denoted using the Universal/National Numbering System as A through T;

(50) "Primary care dentist" means 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;

(51) "Prior authorization" means approval from the department or its designee for the provision of a service or the delivery of goods before the provider actually provides the service or delivers the goods;

(52) "Post procedure review" means the post treatment assessment by radiographic and other accompanying documentation of specified services on a case-by-case basis 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;

(53) "Prophylaxis" means the complete removal of calculus, soft debris, plaque, stains and smoothing of unattached tooth surfaces through scaling by rotary, ultrasonic or other mechanical means as described as standard procedure by the American Dental Association. Prophylaxis must include polishing of the teeth and review of oral-hygiene instruction including toothbrush and flossing instruction;

(54) "Prosthodontic services" means the procedures used to repair or replace missing teeth when a great deal of tooth structure is lost due to disease or trauma or used to replace missing teeth;

(55) "Public health hygienist" means 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 in order to provide services in an institution defined in 19a-490, as a community health center, a group home, preschool or school operated by a local or regional board of education;

(56) "Pulpotomy" is the removal of the diseased portion of the connective tissue of a primary or permanent tooth with the intent of maintaining tooth vitality;

(57) "Retrospective review" means the post treatment assessment by radiographic and other accompanying documentation of specified services on a case-by-case basis 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;

(58) "School based dental clinic" means a system of care delivery where either prevention based services or comprehensive dental services are offered either in an operatory contained within the school building or through the use of portable equipment set up at varying locations;

(59) "Screening evaluation" means a basic assessment of the oral condition of an individual performed by a licensed healthcare physician, Physician Assistant, Nurse Practitioner, Dentist or Dental Hygienist;

(60) "Specialist" means a dentist who has taken and passed the practicum for dental licensure and received and successfully completed post graduate training by an accredited program supported by the American Dental Association's CODA leading to a certificate, master degree in dental science,

board eligibility or board certification in any of the following specialty areas of dental medicine:

(A) Anesthesiology 122300000X;
(B) Dental Hygienist 124Q00000X;
(C) Endodontology 1223E0200X;
(D) Oral Pathology 1223P0106X;
(E) Oral Radiology 1223D008X;
(F) Oral Surgery 1223S0112X;
(G) Orthodontics 1223X0400X;
(H) Pediatric Dentistry 1223P0221X;
(I) Periodontics 1223P0300X;
(J) Prosthodontics 1223P0700X;
(K) Public Health Dentist 1223D001X; and
(L) Restorative Dentistry 1223G001X;

(61) Specialty practice" means a practice that holds itself out as a specialty practice or offers selective dental services concurrent with a dental specialty. The dentist must have obtained a certificate in the specialty from a CODA accredited training program. The practice will provide the services that are deemed to be specialty by professional standards. This includes anesthesiology, endodontics, oral surgery, orthodontic, pediatric, periodontic or prosthodontic services;

(62) "Teeth" means "teeth" as described using the Universal/National Numbering System:

(A) Anterior primary teeth are denoted as C through H, M through R;
(B) Anterior permanent teeth are denoted as 6 through 11 and 22 through 27;
(C) Premolar teeth are denoted as 4, 5, 12, 13, 20, 21, 28, 29;
(D) Molar primary teeth are denoted as A, B, I, J, K, L, S and T;
(E) Molar permanent teeth are denoted as 1 through 3, 14 through 19, 30 through 32;
(F) Posterior permanent teeth are denoted as 1 through 5, 12 – 21, 28 through 32;
(G) Posterior primary teeth are denoted as A, B, I through L, S, and T;
(H) Supernumerary permanent teeth are denoted as 51 through 83; and
(I) Supernumerary primary teeth are denoted as AS through TS;

(63) "Tooth surfaces" means "tooth surfaces" using the following designations:

(A) Distal (D) - Surface furthest from the midline;
(B) Facial (F) - Facing the mucosa;
(C) Incisal (I) – Edge of anterior teeth;
(D) Lingual (L) - Facing the tongue;
(E) Mesial (M) – closest to the midline; and
(F) Occlussal (O) - of the posterior teeth;

(64) "Transitional dentition" means the period where the primary dentition is in the process of being exfoliated and replaced by permanent dentition;

(65) "Treatment plan" means a detailed list of dental procedures organized in descending order from urgent to less urgent treatment needs, which are necessary to maintain and restore the member's oral health;

(66) "Unilateral removable appliance" means a dental appliance or device that is prescribed, constructed and placed in or on a patient by a dentist as part of a treatment protocol for the sole purpose of addressing anomalies or deficiencies on one side of the oral cavity, dental quadrant or with the facial structures;

(67) "Utilization review" means 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;

(68) "Vestibuloplasty" means any of a series of surgical procedures designed to restore alveolar ridge height by lowering the muscles attached to the buccal, labial and lingual aspects of the jaws.

(NEW) Sec. 17b-262-1008. Provider Participation

(a) In order to participate in the Connecticut Medicaid Program and provide dental services eligible for reimbursement from the department, each dental provider shall:

(1) Comply with all applicable licensing, accreditation and certification requirements;

(2) Comply with all departmental enrollment requirements, including sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;

(3) Have a valid provider enrollment agreement on file with the department and comply with the provider participation agreement entered into with DSS;

(4) Cooperate with investigations of quality concerns, including, but not limited to, review of the quality of care rendered by the provider; visits at the provider's site of service or business address; and quality improvement or corrective action plans for the provider.

(b) In addition to satisfying the requirements of subsection (a) of this section , a dental home shall:

(1) Provide comprehensive care (restoration of cavities, root canal therapy, prosthetic services and extractions) in addition to primary dental care prevention and emergency services;

(2) Be accessible and have a fixed location for the provision of continuity of services that is within a twenty mile radius of the patient base, is close to the patient's home and have regularly scheduled appointment hours available weekly including the summer months;

(3) 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; and

(4) Have the capacity to make referrals to specialists if needed, within the patient's established dental plan's network;

(c) In addition to satisfying the requirements of subsection (a) of this section, dental specialty practices shall:

(1) Employ at least one dental specialist;

(2) 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

(3) 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.

(d) Mobile dental clinics and school based health centers shall:

(1) Have or contract with a dental home office of a fixed location where a Connecticut Medicaid enrolled licensed dentist maintains the diagnostic imaging, diagnostic tests and charts of treated patients and accepts and treats patients from the mobile dental clinic or school based health center as a patient of record;

(2) Provide or place referred patients into comprehensive dental care for services such as restorations, endodontic treatment or extractions. The dentist shall be able to handle emergencies on a 24 hour, seven day a week basis;

(3) Be limited to submitting claims for services provided within a geographic area that is no greater than 15 miles of the mobile clinic's fixed dental location or the school based health center;

(4) Review each member's service history before rendering treatment. If the member has a dental home, the mobile clinic or school based health center shall consult with the dentist of record before performing any treatment to the members;

(5) 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:

(A) All permission slips shall clearly state that the services being offered are in lieu of care

provided at the member's dental home.

(B) The permission slip shall be valid for one date of service which shall be specified on the permission slip.

(C) The permission slip shall clearly state each procedure that will be performed including tooth number if applicable. Global generalizations (i.e. preventive services, restorations) shall not be considered acceptable for obtaining permission from a legal guardian.

(6) Have all written materials available in English and a proficient Spanish version written at no greater than a seventh grade reading level;

(7) Any mobile clinic or school based health center that works with local dentists or clinics to function as the primary care dentist and the dental home must have a written contract with the clinic or dentist. The key features are as follows:

(A) The subcontracted dentist or dental clinic shall be a Medicaid enrolled provider.

(B) The subcontracted dentist or dental clinic shall be subject to all Medicaid policies and regulations.

(C) The members may be referred to and receive comprehensive care from one primary care dentist, excluding treatment by dental specialists when the need arises.

(D) The mobile clinic shall provide all administrative support necessary to ensure that members receive all of the same services the patient would receive if the members were being served at a fixed dental home located in the community.

(E) All patient records shall be placed in the primary care dentist or dental home office within five business days of providing dental services in the mobile clinic.

(NEW) Sec. 17b-262-1009. Eligibility

Payments for dental services shall be available for members enrolled in Connecticut Medical Assistance Program.

(NEW) Sec. 17b-262-1010. Administrative Services Organization

(a) The department may contract with an ASO to administer dental health services in accordance with a contract between the ASO and the department.

(b) The ASO shall assist the department in developing, managing and maintaining a comprehensive network of dental providers that has the capacity to deliver all covered services to members. The ASO's responsibilities may include, but are not limited to:

(1) Network management and development;

(2) Development of a comprehensive provider database; and

(3) Evaluation of the adequacy of the provider network.

(c) The ASO shall identify individuals who may need case management or care coordination and offer such services to individuals who are not already receiving case management services from their primary care dental provider.

(d) The ASO shall be responsible for member services.

(e) The ASO shall be responsible for a quality management program.

(f) The ASO shall be responsible for utilization review and utilization management and shall develop a utilization review and utilization management program subject to the review and approval of the department.

(g) The ASO shall assist with programmatic and financial reporting.

(h) The ASO shall implement a prevention and intervention strategy for identified members to reduce poor oral health habits and prevent oral disease.

(i) The ASO may investigate and address concerns related to the quality of care rendered by providers.

(j) The ASO may physically examine patients to evaluate the appropriateness, quality and type of care rendered.

(NEW) Sec. 17b-262-1011. Services covered and limitations

(a) Adjunctive Services shall be covered as follows:

(1) General anesthesia and conscious sedation administered by a dentist or oral and maxillofacial surgeon, who holds a valid Dental Anesthesia Conscious Sedation Permit issued pursuant to section 20-123b of the Connecticut General Statutes:

(A) To provide prevention in conjunction with endodontic, restorative services or oral surgical procedures for members under the age of twelve;

(B) For use with members undergoing in office oral surgical procedures where sedation is required to perform the procedure secondary to trauma or infection; and

(C) For members over the age of twelve who have a demonstrated significant cognitive impairment or who require behavior management related to the procedures to be performed;

(D) For the extraction of third molars provided that removal of the third molars is medically necessary; and

(E) With the following documented in the member's chart:

(i) the member's cognitive or behavioral health diagnosis which can be fulfilled by a physician's letter or certificate from another state agency that services the member;

(ii) the type of agent utilized and any other drug administered including the dose(s), time given and route of administration;

(iii) the induction time of the anesthetic agent administered and the stop time of the anesthetic agent; and

(iv) the member's vital signs pre, during and post anesthesia administration.

(2) Inhalation conscious sedation for members who are under the age of twelve or members of any age who have a diagnosis of a documented cognitive disorder which supports the need for behavior management related to the dental procedures to be delivered.

(3) Behavior Management for members who are under the age of six or have documented cognitive impairments.

(A) Techniques must be employed in conjunction with the delivery of dental services to individuals who are under the age of six or have a cognitive diagnosis such as autism, cerebral palsy, hyperactivity disorder, acquired brain injury and moderate to profound developmental delay as determined by the attending physician or the Department of Developmental Services.

(B) The member's chart shall contain the following documentation:

(i) A brief description of the member's illness or disability including the diagnostic code;

(ii) If the member is under six years of age and does not have a cognitive disability, then a description of the behaviors warranting behavior management; and

(iii) A letter from the member's attending physician certifying the diagnosis or if the member is a member of the Department of Developmental Services, the member's certificate will meet the documentation requirements.

(4) Care related adjunctive services, including the following:

(A) Care coordination provided by dental health care specialists or other non-dental professionals to facilitate delivery of dental services to a member; and

(B) Case management when the coordination of dental care is delivered by a dentist or under the direct supervision of a dental professional for a member who has a complicating medical condition.

(5) Home or facility visits, one time per facility per day.

(6) Inpatient hospital services approved by the Department as medically necessary by either a preadmission or retrospective review and provided by licensed dental professionals acting within the

dental professional's scope of the practice.

(7) Outpatient hospital services provided by licensed dental professionals acting within the dental professional's scope of the practice.

(8) Intra-oral sleep apnea devices with prior authorization for members one time per two year period for custom-fitted laboratory-processed devices designed to minimize the effects of sleep disturbance related to airway pathologies as documented by a sleep study. All follow-up care shall be included in the payment for this service.

(b) Diagnostic Services shall be covered as follows:

(1) Oral Examinations

(A) One initial oral comprehensive examination per member and performed by a general or pediatric dentist or prosthodontist. The examination shall include the taking of the medical history, the thorough evaluation and recording of the state of both intra-oral and extra-oral hard and soft tissues findings resulting in a new treatment plan for the member;

(B) One detailed and extensive examination per member and performed by an anesthesiologist, endodontist, oral and maxillofacial surgeon, orthodontist, pathologist, periodontist or radiologist;

(C) A periodic oral examination performed by a dentist six months after the initial oral comprehensive examination and every six months thereafter for members under the age of twenty one;

(D) An annual oral examination performed by a dentist for members over the age of twenty one unless a health (medical or dental) condition warrants treatment every six months;

(E) A problem focused oral examination may be performed by a dentist, two times per member in a twelve month period. A problem-focused oral examination shall not be reimbursed in conjunction with other examination codes, routine or previously scheduled dental care or palliative treatment;

(F) A screening examination may be performed by a physician, public health hygienist, nurse practitioner or physician assistant one time per member every twelve months with the following requirements:

(i) The screening examination results shall be documented on the department's "Screening for Oral Health" form and submitted to the department for reimbursement; and

(ii) A screening examination shall not be covered when performed in a dental office, at the member's dental home or in a federally qualified health center.

(2) Diagnostic imaging shall be covered when taken in compliance with accepted criteria and practices specified by state and federal standards governing radiation hygiene, developed by the National Council on Radiation Protection and Measurements including the guidelines adopted by the U.S. Department of Health and Human Services and the ADA. Diagnostic imaging should be taken according to the accepted standards of dental care and according to a specific member's needs. Diagnostic imaging shall be limited to the minimum number needed to diagnose a member's condition, shall be correctly mounted and clearly identify the patient's right and left sides, and shall be of diagnostic quality in order for the department to reimburse the provider. The following diagnostic imaging services shall be covered:

(A) One set of bitewing films per member in a twelve month period as follows:

(i) Bitewing films are included in the complete mouth series and shall not be reimbursed separately from a complete mouth series or where a panoramic radiograph is substituted for a complete mouth series;

(ii) No more than four bitewing films may be taken per visit;

(iii) Additional bitewing images may be prior authorized for members who have had a diagnosis of white spot lesions or interproximal decay within the previous twelve months.

(B) One cephalometric image per orthodontic and oral surgical providers for orthodontic cases requiring orthognathic surgery.

(i) Additional cephalometric images may be prior authorized for members who have dento-facial anomalies; and

(ii) For members over the age of twenty one in the event of facial trauma or reconstruction.

(C) Either one complete series or a panoramic film plus bitewing diagnostic imaging one time per three year period for members over the age of twelve.

(i) All complete series shall be properly mounted and the patient's right and left sides shall be clearly identified; and

(ii) Panoramic images shall have the right and left sides clearly identified.

(D) 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. Additional cone beam imaging may be prior authorized for members who have dento-facial anomalies.

(E) Occlusal imaging one time per arch every two years and shall not be reimbursed for routine screening purposes. Additional occlusal images may be prior authorized for members who have dento-facial anomalies.

(F) A panoramic image one time per three-year period for members twelve years of age and over. The panoramic radiograph may be taken with bitewing diagnostic imaging in lieu of the complete series and shall have the right and left sides clearly identified.

(G) One initial periapical image and up to three additional images annually per member or four periapical films in total per member subject to the following limitations:

(i) Shall not be covered for routine screening services for children or adults;

(ii) Shall not be covered on an individual basis when ten or more periapicals are taken over multiple visits to constitute a complete series;

(iii) Other than the initial diagnostic periapical radiograph, shall not be covered on the same day endodontic therapy is initiated on the same tooth; and

(iv) If two or more periapical radiographs are taken on the same day, the first periapical shall be coded as the first periapical images and subsequent periapical images shall be coded as additional periapical images.

(H) Tempromandibular imaging for each joint with prior authorization.

(3) Diagnostic testing to determine susceptibility to caries and other dental diseases. Caries susceptibility test includes the collection of saliva, plaque, carious dentin for the evaluation and determination of the relative risk rate of future caries development for children who have predominantly primary dentition.

(c) Endodontic Services shall be covered as follows:

(1) Apexification one time per tooth for members up to the age of eighteen, including all visits needed to complete the treatment excluding final root canal therapy.

(2) Apicoectomy one time per tooth when the prognosis of the tooth is favorable. Apicoectomy therapy for members over the age of twenty-one when the quadrant is not missing any teeth with the exception of third molars or premolars that have been extracted for orthodontic purposes. There shall be no active periodontal disease, at least 50% alveolar bone remaining and an adequate tooth structure shall remain to restore the tooth to form and function.

(3) Anterior endodontic therapy

(A) For members under the age of twenty-one when the prognosis for the treated tooth and dentition is favorable, there is at least 50% alveolar bone remaining and there is no active periodontal disease. An adequate tooth structure shall remain to restore the tooth to form and function.

(B) For members over the age of twenty-one when the prognosis is favorable, there is at least 50% alveolar bone remaining and there is no active periodontal disease. An adequate tooth structure shall remain to restore the tooth to form and function.

(i) The tooth to be endodontically treated must be in occlusion with a natural tooth or the opposing tooth will be immediately restored or replaced with an artificial tooth; and

(ii) Is not covered for a tooth where the member expects to receive a removable partial denture replacing at least one tooth in the same arch as the tooth to be treated or has bilaterally missing teeth in the same arch.

(4) Premolar endodontic therapy

(A) For members under the age of twenty-one when the prognosis for the treated tooth and dentition is favorable, there is at least 50% alveolar bone remaining and there is no active periodontal disease. An adequate tooth structure shall remain to restore the tooth to form and function.

(B) For members over the age of twenty-one when there are no missing anterior teeth, or the member is missing all molars in the same quadrant. There shall be no active periodontal disease, at least 50% alveolar bone remaining and an adequate tooth structure shall remain to restore the tooth to form and function, provided that:

(i) The tooth to be endodontically treated is in occlusion with a natural tooth or the opposing tooth shall be immediately restored or replaced with an artificial tooth; and

(ii) The member does not have a removable partial denture replacing at least one tooth in the same arch as the tooth to be treated or has bilaterally missing teeth in the same arch.

(5) Molar endodontic therapy

(A) For members under the age of twenty-one when the prognosis for the treated tooth and dentition is favorable, there is no active periodontal disease, there is at least 50% alveolar bone remaining and an adequate tooth structure shall remain to restore the tooth to form and function.

(B) For members over the age of twenty-one when the quadrant is not missing any teeth with the exception of third molars or premolars that have been extracted for orthodontic purposes. There shall be no active periodontal disease, at least 50% alveolar bone remaining and an adequate tooth structure shall remain to restore the tooth to form and function.

(i) The tooth to be endodontically treated must be in occlusion with a natural tooth or shall be restored with an artificial tooth;

(ii) Is not covered for a tooth where the member expects to receive a removable partial denture to replace at least one tooth in the same arch as the tooth to be treated or has bilaterally missing teeth;

(iii) Is not covered when teeth are absent in a quadrant unless the tooth is needed to function as a rest for the placement for a removable partial denture; and

(iv) Is not covered for second or third molars.

(6) All endodontic therapy procedures on permanent dentition require post procedure review for all providers with the exception of endodontists.

(7) Direct pulp cap for members under the age of twenty one.

(8) Obturation or canal preparation for the retreatment for each canal of a previously root canal treated tooth for members under the age of twenty- one.

(9) Pulpotomy for members under the age of twenty-one where the vitality must be maintained, subject to the following limitations:

(A) The primary tooth that has been treated by a pulpotomy must be restored with a stainless steel crown restoration.

(B) Pulpotomy may not be performed:

(i) on a primary tooth nearing exfoliation;

(ii) when periradicular pathology extends into the underlying developing tooth bud (the tooth is non – vital); and

(iii) if excessive internal root resorption has occurred or the pulp floor naturally or iatrogenically opens into the bifurcation.

(C) Is not covered for a permanent tooth by the same provider that is expecting to perform

complete root canal therapy within a one year period after the pulpotomy has been performed.

(10) Retreatment of previous root canal therapy is covered for members under twenty-one years of age.

(d) Oral and Maxillofacial Surgery Services shall be covered as follows:

(1) Alveoloplasty when three or more contiguous teeth are extracted;

(2) Biopsy;

(3) Bonding device (ligation) to facilitate eruption of an impacted tooth;

(4) Bone grafting when performed in conjunction with a surgical procedure;

(5) Fracture reduction;

(6) Non-surgical exodontia;

(7) Orthognathic surgery when the member has one of the following:

(A) Acute traumatic injury and post-surgical sequel that require reconstruction;

(B) Resection of cancerous or non-cancerous tumors and cysts, cancer and post-surgical sequel that require re-construction to restore form and function;

(C) Obstructive sleep apnea where other non-invasive modalities of treatment have failed;

(D) Cleft palate; or

(E) Congenital abnormalities that meet the criteria for reconstruction depending upon a patient-specific clinical review and include, but are not limited to the following:

(i) Midface hypoplasia;

(ii) Mandibular Prognathism; and

(iii) Hemifacial microsomia.

(8) Orthognathic surgery only when it has been approved by the Department and the member is undergoing active orthodontic treatment and has any of the following facial skeletal abnormalities that cannot be corrected to function through orthodontic therapy associated with masticatory malocclusion after undergoing corrective orthodontics:

(A) Anteroposterior discrepancies which are defined as:

(i) Maxillary/mandibular incisor relationship with overjet of 5mm or greater or a negative value of 3 mm or greater; or

(ii) Maxillary/mandibular anteroposterior molar relationship discrepancy of 4mm or greater.

(B) Transverse discrepancies:

(i) Total bilateral maxillary palatal cusp to mandibular fossa discrepancy of 4 mm or greater; or

(ii) A unilateral discrepancy of 3 mm or greater given normal axial inclination of the posterior teeth.

(C) Vertical discrepancies:

(i) The presence of a vertical facial skeletal deformity which is two or more standard deviations from the published norms for skeletal landmarks;

(ii) Open bite and no vertical overlap of the anterior teeth;

(iii) Unilateral or bilateral posterior open-bite greater than 4 mm;

(iv) Deep overbite with impingement or irritation of the buccal or lingual soft tissues of the opposing arch; or

(v) Super eruption of a dentoalveolar segment due to lack of occlusion.

(D) Anteroposterior, transverse or lateral asymmetries greater than 3 mm with concomitant occlusal asymmetry and one of the following:

(i) Masticatory disfunction due to skeletal malocclusion; or

(ii) Speech abnormalities determined by a speech pathologist or therapist to be due to a malocclusion and not helped by orthodontia or at least 6 months of speech therapy.

(E) Obstructive sleep apnea that is moderate or severe as measured by polysomnography, objective documentation of hypopharyngeal obstruction, failure of nonsurgical treatment, including a

good faith effort at CPAP or BIPAP, and an expectation that orthognathic surgery will decrease airway resistance and improve breathing.

(F) Difficulty swallowing with significant weight loss or failure to thrive documented in the member's medical records for a period of 4 months or longer, a low body mass index and low serum albumin related to malnutrition.

(9) Reimplantation of an anterior tooth or teeth for members under the age of twenty-one;

(10) Ridge augmentation;

(11) Surgical access and ligation of an unerupted tooth for members under the age of twenty-one;

(12) Surgical exodontia, except for the prophylactic removal of third molars. Removal of impacted teeth requires supporting documentation for the need for the service;

(13) Surgical treatment of dento-facial abnormalities, trauma or diseased states.

(A) Condylectomy or coronoidectomy;

(B) Mass or tissue removal;

(C) Open reduction, internal fixation of fractures;

(D) Oro-facial reconstruction; or

(E) Temporomandibular joint surgery.

(14) Surgical placement of temporary anchorage devices;

(15) Suture of wounds is not a covered benefit when the laceration is caused by a surgical procedure or occurs secondary to extraction(s) or trauma resulting from a surgical procedure;

(16) Transplantation of a tooth or tooth bud for members under eighteen years of age; and

(17) Vestibuloplasty to create a stable ridge for denture prostheses.

(e) Appliance therapy for members under twenty-one years of age:

(1) For interceptive orthodontic purposes when documentation, including a description of the condition, the type of interceptive orthodontics proposed, models, radiographs and photographs, demonstrates the need to correct:

(A) Anterior crossbite causing gingival recession of lower involved anterior teeth or destruction of the incisal surface(s);

(B) Severe overjet with deep impinging overbite;

(C) Posterior cross bites with functional deviation of the mandible;

(D) Anterior impactions that endanger the vitality of the adjacent teeth;

(E) Severe open bites 8 mm or greater; or

(F) Spacing deficiencies by influencing the development phase of jaw growth.

(2) Habit-breaking appliances with documentation of the significant effects of the habit; and

(3) Members may or may not subsequently qualify for comprehensive orthodontic therapy after completion of appliance therapy.

(f) Periodontal Services shall be covered as follows:

(1) Periodontal therapy for members who have undergone chemotherapy, radiation therapy to the head and neck and/or organ transplantation.

(2) Periodontal therapy for treatment of quadrants with three or more contiguous teeth when medically necessary.

(3) Periodontal therapy may not be performed in conjunction with prophylaxis or extraction of teeth or other surgical procedures.

(4) Covered non-surgical procedures include:

(A) Full mouth debridement to facilitate evaluation limited to one time per member with prior authorization;

(B) Periodontal maintenance limited to two times per year when a member has previously undergone periodontal treatment; and

(C) Scaling and root planning of the root surfaces and crowns of teeth limited to one time per

quadrant during a one year period for members under the age of twenty-one when medical necessity is documented and the procedure is prior authorized.

(5) Covered surgical procedures:

(A) Gingivoplasty and gingivectomy limited to one time per quadrant during a one year period; and

(B) Gingival flap procedure including root planning limited to one time per quadrant per lifetime for members under the age of twenty-one with medical necessity documented and prior authorization.

(6) Any requested periodontal procedure shall clearly state the nature of the medical condition, provide a complete image series (panoramic is not acceptable), periodontal charting and description of the oral hygiene condition. Intra-oral photographs shall be acceptable adjunctive documentation.

(7) Members who are eligible and required periodontal services shall review and sign the department's form, "Periodontal Therapy."

(g) Preventive Services shall be covered as follows:

(1) Athletic guards for members under the age of twenty-one who are engaged in a contact sport and who have no other means for the provision of the guard for the members.

(2) Occlusal guards for members one time per two year period for custom-fitted laboratory-processed occlusal guards designed to minimize the effects of occlusal related pathologies. All follow-up care shall be included in the payment for this service.

(3) Topical application of fluoride or a professional anti-cariogenic agent for members under the age of twenty-one, one time per every six month period, in conjunction with dental prophylaxis.

(4) Topical fluoride application for adults over the age of twenty one (21) years of age shall be covered when the member has eight or more teeth and:

(A) the member resides in a long term care facility;

(B) the member has a significant cognitive impairment;

(C) the member has undergone or is currently on intravenous or injected biphosphanate therapy;

(D) the member has undergone head and neck radiation treatment;

(E) the member has xerostomia secondary to autoimmune disease or medications; or

(F) the member has a debilitating illness where the recipient cannot maintain proper oral hygiene.

(5) Custom fluoride trays one time every two years for members that have undergone head and neck radiation.

(6) Prophylaxis shall include the mechanical removal of plaque and calculus of the teeth and review with the members or the member's caregiver, oral hygiene instruction, including the appropriate technique for brushing the teeth and flossing. Prophylaxis shall be covered as follows:

(A) For members under the age of twenty one, one time every six months.

(B) For members who are over the age of twenty one, limited to one time per year for a healthy adult or where there are no dental or medical conditions that warrant additional prophylaxis procedures

(7) Screening or Risk Assessment shall be accompanied by the submission of the risk assessment form used for members under the age of twenty-one in order to obtain reimbursement.

(8) Sealants one time per three year period per members for non-carious teeth for pits and fissures in the permanent dentition. The repair or replacement of a sealant shall not be covered until three years have lapsed from the initial placement of the sealant.

(A) All teeth that are candidates for sealant placement shall be free from decay and shall have erupted sufficiently that proper isolation can be achieved for sealant placement.

(B) Sealant placement shall be reimbursed on a per tooth basis and includes all of the following:

(i) All surfaces of the permanent molar tooth;

(ii) Proper preparation of the enamel surface;

(iii) Etching, placement and finishing of the sealant; and

(iv) Reapplication by the same provider if the sealant fails in less than three years.

(C) Sealant placement shall be subject to the following age limitations:

(i) On the first molar teeth for members from age five to age sixteen;

(ii) On second molar teeth from the age eleven to sixteen;

(iii) Primary molars only in the case of the presence of early childhood decay or high caries susceptibility test by prior authorization; and

(iv) For premolar teeth only in the case of the member having a high caries susceptibility test or by prior authorization.

(9) Space maintainers when there is a premature loss of primary teeth that may lead to the loss of the developmental integrity of the lower or upper arch, or when the premature loss of primary molars occurs and placement is necessary to prevent the migration of adjacent teeth. The member's chart shall contain the initial radiograph of diagnostic quality, supporting the need for a space maintainer showing the unerupted permanent tooth or that migration of the adjacent tooth is in the initial stages. Only one space maintainer shall be covered per members per area, regardless of the reason.

(h) Prosthodontic Services shall be covered as follows:

(1) Complete and removable partial dentures provided for functional purposes that are provided by any dentist shall require prior authorization.

(A) For members over the age of twenty-one years of age, if the member or the member's caregiver can care for the denture, the recipient has the ability to benefit from the denture(s) and the member uses the denture prosthesis on a daily basis;

(B) Adjustment services are included in the six (6) month post denture delivery period and adjustment services are not billable separately;

(C) Replacement dentures shall be provided one time in each seven year period regardless of the reason.

(i) Replacement dentures shall not be approved if lost within the first year of placement regardless of the reason for loss.

(ii) After the receipt of replacement dentures within the seven year time limitation, the member shall not be eligible to receive another set of dentures for seven years from the date of delivery regardless of the reason.

(iii) In cases where there are catastrophic reasons for the loss of the removable complete or partial denture prosthesis, the request for prior authorization must include a statement from the member or his or her representative explaining the nature of the loss or destruction. In cases where the denture is missing or destroyed due to theft, an accident or fire, the member shall provide a copy of the police or fire marshal incident report.

(iv) In cases where the member resides in a long term care facility, a copy of the member's dietary record log prior to and after the loss of the denture(s) shall be required.

(v) Replacement denture prosthesis shall only be considered for purposes of mastication, excluding replacement for the reasons of cosmetics and phonation. Reasons of medical necessity shall be provided and substantiated by the dentist. A note from a physician stating that dentures are needed or are medically necessary does not constitute medical necessity.

(vi) Replacement dentures are subject to the same requirements of the placement of initial denture prosthesis.

(D) Removable partial dentures are provided when the members have less than eight posterior teeth in functional occlusion.

(i) In the absence of qualifying posterior missing teeth, the members may have at least one or more missing anterior teeth.

(ii) When both maxillary and mandibular dentures are requested and either a maxillary or mandibular denture will restore the patient to at least eight posterior teeth in occlusion, then the

denture that restores the posterior occlusion shall be approved.

(iii) If the members must progress to a complete denture within the first two years of placement of the partial denture(s) by the same provider then the money for the partial denture shall be recouped.

(iv) All hygiene, restorative and oral surgical procedures shall be completed prior to requesting prior authorization and before constructing the partial denture(s).

(2) Denture labeling shall be reimbursed for members who reside in long-term care facilities only.

(3) Delivery of Dentures

(A) The date of service for reimbursement purposes as defined in the provider contract reflects the date of delivery of the permanent prosthesis.

(B) The provider shall have the patient sign the department's form acknowledging the receipt and acceptance of the denture, provide an explanation of the department's replacement policy, maintain the documentation in the patient's chart and shall give the brochure "Caring for Your Dentures" to the patient.

(4) Repair of denture(s) shall be covered after twelve months from the date of initial delivery, unless an unusual undocumented circumstance applies, as follows:

(A) Reline or rebase of denture prosthesis six months after post-denture prosthesis delivery;

(B) Cold-cure office procedures one time per prosthesis every twelve months; and

(C) Laboratory-processed procedures every twelve months.

(5) Fixed Partial Dentures for members under the age of twenty one who have congenitally missing or traumatic loss of anterior teeth may be covered with prior authorization and subject to the following limitations:

(A) Acid etch or "Maryland" bridgework shall be the only type of fixed bridgework covered.

(B) The member shall have all decay treated and shall be free from periodontal disease;

(C) The member's abutment teeth shall be sound; and

(D) The member shall be able to maintain oral hygiene, which includes brushing and flossing on a daily basis.

(i) Restorative Services shall be covered as follows:

(1) Amalgam and composite (restoration) fillings performed by the same provider shall be limited to one restoration per every two years to the same tooth regardless of the number of surfaces treated.

(A) More than one amalgam or composite restoration placed on a single surface shall be considered a single restoration. The predominant material (amalgam or composite resin) used for the restorations shall be the material used for determining the billing code.

(B) More than one amalgam or composite (restoration) filling placed in multiple separate surfaces on a tooth is considered a multi-surface restoration counting duplicative surfaces as one surface. If multiple restorative materials are used, the predominant material shall be the material used for determining billing codes.

(C) More than one amalgam or composite (restoration) fillings placed in two separate locations (the buccal pit or lingual groove) on the first permanent molars (tooth numbers 3, 14, 19 and 30) shall be considered separate restorations.

(i) On the first permanent maxillary molars (teeth numbers 3 and 14), the distinction is limited to the oclussal – lingual surfaces.

(ii) On the first permanent mandibular molars (teeth 19 and 30) the distinction is limited to the occlusal - buccal surfaces.

(D) Placement of liners bases and the final polishing shall be considered part of the restoration procedure.

(E) Composite resin restorations shall not be covered as follows:

(i) More than fifty percent of the dentin structure is lost on a posterior tooth;

(ii) In primary teeth that have undergone a pulpotomy; or

(iii) It is a temporary filling between endodontic treatment appointments.

(2) Artificial crowns

(A) For all members under the age of twenty-one and at least sixteen years of age where root formation is complete;

(B) For members over the age of twenty-one where the crown may be 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;

(C) Members with bilaterally missing teeth in the same arch are not eligible for multiple, single crowns to restore deteriorated dentition unless the crowns will form the last remaining abutment tooth/teeth in an arch for partial denture placement.

(D) Crown types covered:

(i) Cast Crowns on all permanent teeth;

(ii) Milled crowns which follow the regulations for crowns on anterior premolar and molar teeth;

(iii) Porcelain fused to metal crowns on anterior and premolar teeth; and

(iv) Stainless-steel crowns on primary teeth or permanent teeth provided the root apices are open and tooth eruption is complete in permanent teeth.

(3) Core build up when greater than fifty percent of the tooth structure is missing, subject to the following:

(A) Shall not be used in conjunction with or when a tooth has received an amalgam or composite restoration; and

(B) Shall not be used in conjunction with a stainless steel crown on a primary tooth.

(4) Pin retention.

(5) Sedative filling shall be covered for vital teeth one time per tooth per year.

(6) Replacement of the existing artificial crown shall be covered only when the crown becomes defective in the permanent teeth after a seven year period has lapsed.

(7) Replacement of a stainless steel crown in the primary dentition shall be covered if the crown is lost and only if the tooth is not nearing exfoliation. Replacement of a lost crown on a permanent tooth will be reimbursed after a three year period has lapsed by the same provider.

(NEW) Sec. 17b-262-1012. Services not covered

The department shall not cover the following services:

(a) Adjunctive Services:

(1) General anesthesia and conscious sedation:

(A) For members over the age of twelve who do not have a cognitive impairment for the extraction of less than six teeth with the exception of the surgical extraction of two or more third molars; or

(B) For members over the age of twenty one who do not have trauma, an oro-facial infection or a cognitive impairment for general dental treatment (root canal therapy, retreatment of a root canal, restorative, prophylactic, non – surgical periodontic therapies, orthodontic or prosthodontic procedures); or

(C) If any form of inhalation or intravenous sedation is employed.

(b) Diagnostic Services:

(1) Periapical diagnostic imaging performed on the same date of service as a complete or full mouth series;

(2) Periapical diagnostic imaging taken on the same tooth during endodontic treatment or within fourteen days after endodontic therapy is completed;

(3) Periapical diagnostic imaging taken for general or screening purposes unless infection, trauma

or a developmental abnormality is suspected;

(4) Panoramic diagnostic imaging taken for the purposes of endodontics, periodontics, or for the purpose of diagnosing interproximal decay;

(5) Panoramic diagnostic imaging taken for the purposes of routine screening for children under the age of eight; and

(6) Any images that are not of diagnostic quality.

(c) Endodontic Services:

(1) Apexiogenesis for members over the age of eighteen;

(2) Apicoectomy for members over the age of twenty one with missing teeth in the same quadrant; and

(3) Retreatment of previous root canal treated teeth for members over the age of twenty - one.

(d) Oral Surgical Services:

(1) Alveoplasty in conjunction with single or singular extractions;

(2) Brush biopsy;

(3) Cosmetic surgical services;

(4) Implant placement for the replacement of teeth;

(5) Suture of wounds when the laceration is caused by a surgical procedure or occurs secondary to extraction or trauma resulting from a surgical procedure;

(6) Orthognathic surgery for members over the age of 30 who do not have a severely handicapping malocclusion on the Salzmann Handicapping Malocclusion Index;

(7) Orthognathic surgery that is cosmetic and not medically necessary because it is primarily to change physical appearance that would be within normal human anatomic variation;

(8) Genioplasty or anterior mandibular osteotomy that is considered cosmetic and not medically necessary because it is performed to reshape or enhance the size of the chin to restore facial harmony and chin projection and it is not associated with masticatory malocclusion; and

(9) Post-operative follow up visits, including post-operative radiographs, for the first two post-operative visits shall not be reimbursed separately and shall be included in the global fee for surgical procedures.

(e) Periodontal Services:

(1) Any surgical periodontal procedure without obtaining prior authorization through a request for EPSDT special services;

(2) Any non-surgical chemotherapeutic or mechanical periodontal therapies without obtaining prior authorization through a request for EPSDT services;

(3) Scaling and root planing without obtaining prior authorization;

(4) Splinting of teeth without obtaining prior authorization through a request for EPSDT services; and

(5) Periodontal therapy for members with poor oral hygiene or who have a history of smoking or substance abuse. Periodontal therapy shall be discontinued for members who do not comply with hygiene, home care instructions or appointments.

(f) Preventive Services:

(1) Counseling or education services;

(2) Habit breaking devices, unless orthodontic treatment is approved;

(3) Oral hygiene aids not accessed through durable medical goods vendors (DME vendors);

(4) Prophylaxis by the use of oral chemical agents;

(5) Removable unilateral space maintainers;

(6) Space maintainers for anterior teeth;

(7) Toothbrush prophylaxis; and

(8) Athletic guards for members over the age of twenty-one.

(g) Prosthodontic Services:
(1) Cosmetic dentistry;
(2) Fixed Partial Dentures (Bridges);
(3) Immediate dentures;
(4) Implants and associated abutments or attachments;
(5) Implant sustained crowns;
(6) Laminate veneers;
(7) Nesbit partial dentures;
(8) Office visits to obtain a prescription where the need for such prescription has already been ascertained;
(9) Complete or partial removable dentures for members who are in a semi-conscious or unconscious state; and
(10) Unilateral partial denture prosthesis
(h) Restorative Services:
(1) Cosmetic dentistry;
(2) Coping restorations;
(3) Gold foil restorations;
(4) Direct or indirect inlays or onlays;
(5) Labial veneers;
(6) Provisional crowns;
(7) Unilateral removable appliances;
(8) Placement of an indirect pulp cap;
(9) Procedures to teeth nearing exfoliation or to teeth that are non-restorable;
(10) Procedures to teeth with less than 50% bone support or significant periodontal involvement;
(11) Posterior resin restorations on molar teeth for members over the age of twenty-one;
(12) Posterior composite resin restorations of any type for third molar teeth;
(13) Posterior composite resin restoration when the restoration is subgingival;
(14) Posterior composite resin restorations when used in a restoration to replace an occlusal cusp;
(15) Resin restorations for a primary tooth that has undergone a pulpotomy or pulpectomy.
(i) Any procedure, service or goods not explicitly allowed pursuant to section 17b-262-866 of the Regulations of Connecticut State Agencies.
(j) Any service or good that is not covered or approved by Medicaid for a member may be paid by the member if she or he chooses as a private pay patient. 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 being non-covered by Medicaid and include a payment schedule if applicable for the non-covered procedure.
(k) Any procedure or service which is not listed on the dental fee schedule is not covered unless authorized for members under the age of twenty-one through EPSDT.
(*l*) Any procedure that has been attempted but not completed.
(m) Any procedure that is an upgrade to the Medicaid covered procedure where the member is balanced billed for the difference.
(n) Any service divided into smaller components of treatment that is by common definition and standards of care included in a single CDT code.
(o) Cancelled or missed appointments.
(p) Office visits to obtain a prescription when the need has already been determined.
(q) Procedures, treatments or surgeries of an unproven, experimental or research nature or that are not proven as safe or effective as documented by peer review literature and best practices.
(r) Procedures, treatments or surgeries in excess of 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.

(s) Scheduling appointments.

(t) Admitting services or any inpatient dental services performed by the admitting dentist if the admission was not approved by the department or its designee as medically necessary in either a preadmission or post procedure review.

(u) Services, procedures or dentures not provided.

(NEW) Sec. 17b-262-1013. Documentation

(a) The member's chart and dental records shall contain the following information:

(1) The member's full name, first, middle and last name;

(2) The member's residential and mailing address;

(3) The member's date of birth;

(4) The member's phone number;

(5) The member's Medicaid identification number and social security number;

(6) Third party insurance coverage, if applicable;

(7) Medical history, including a listing of current pharmaceuticals;

(8) Charting of the member's present and missing teeth;

(9) Charting of the member's restorations, fixed dental appliances and removable prosthetic appliances for general dentists, pediatric dentists, prosthodontists and public health dentists;

(10) Charting of the member's periodontium for general dentists, prosthodontists, periodontists and public health dentists;

(11) The treatment plan for the member and a signed consent form;

(12) The date and written or electronic signature with each entry in the member's dental chart. Initials are not acceptable;

(13) 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;

(14) Notes regarding any diseased states, unusual circumstances or conditions;

(15) For periapical images that are not taken in conjunction with a complete or full mouth series, the provider shall document the reason for taking the periapical x-ray and include the tooth numbers;

(16) All imaging shall be properly labeled and shall include the date the images were taken;

(17) The member's diagnosis and the reason for the procedure being performed; and

(18) A copy of any required departmental dental forms.

(b) 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. Storage of the patient record contents offsite is acceptable if the documentation can be accessed as needed.

(NEW) Sec. 17b-262-1014. Need for Service and Authorization Process

(a) The need for a dental service includes any services that are deemed by the department to be medically necessary and that:

(1) Are within the scope of the dentist's practice; and

(2) Are made part of the recipient's medical record.

(b) In order to receive payment from the department, each dental provider shall comply with all prior authorization requirements. The department in its sole discretion determines what information is necessary to approve a prior authorization request. Prior authorization does not guarantee payment

unless all other requirements for payment are met, including the member being eligible for services at the time of service.

(c) Prior authorization or post-procedure review of dental services shall be determined by patient age and the dental taxonomy of the rendering dentist in accordance with the following:

(1) Procedures that require prior authorization and post procedure review by the department or its designee may be found adjacent to the dental code on the department's Dental Fee Schedule;

(2) Providers shall submit requests for prior authorization to the department or its designee electronically through a secure portal or by submitting a completed request on an American Dental Association claim form;

(3) Supporting documentation shall include the following:

(A) Charted records of the dentition and soft tissue;

(B) Documentation of a condition or disease state from another healthcare provider or agency;

(C) Models of the dental arch with bite registration when appropriate;

(D) Photographs;

(E) Diagnostic imaging;

(F) Treatment notes;

(G) Post procedure review requests shall contain the date of service;

(H) Any teeth expected to be extracted shall be documented on the prior authorization or post procedure review claim form;

(4) All requests for EPSDT related services shall be submitted using a Prior Authorization claim form. The following information shall be included:

(A) Diagnosis;

(B) Supporting medical or diagnostic documentation;

(C) Clinical description of the condition as it presents; and

(D) Proposed treatment plan.

(5) The initial prior or post procedure review authorization period is valid up to twelve (12) months from the date the service is authorized, providing that the patient remains eligible for the Connecticut Medical Assistance Program.

(d) Requests submitted for services that are performed more often than frequency limitations may be allowed in instances of medical necessity and may be requested by prior authorization through the department or its designee.

(e) 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.

(1) The Department or its designee reserves the right to amend any submitted treatment plan based on prognosis and the dental regulations; and

(2) Failure to provide a treatment plan shall result in the denial of services submitted for prior authorization.

(f) Any requests for modifications of any authorized treatment plan or service shall include the reason and supporting documentation for the change. The department or its designee reserves the right to modify treatment plans or dental services to the least expensive but appropriate treatments that will restore form or function as directed by a qualified licensed dentist

(NEW) Sec. 17b-262-1015. Payment

(a) The Commissioner of Social Services shall establish the fees contained in the dental fee schedule annually. The fees shall be based on moderate and reasonable rates prevailing in the respective communities where the services are rendered.

(b) Payments shall be made at the lower of:

(1) The usual and customary charge to the public;

(2) The fee as contained in the dental fee schedule published by the department; or

(3) The amount billed by the provider.

(c) A dental provider who is fully or partially salaried by a hospital, public or private institution, physicians' group, dental group or clinic may not receive payment from the department unless the dental provider maintains an office for private practice at a separate and distinct location from the hospital, institution, physician group or clinic in which the provider is employed.

(d) Dentists who are solely hospital, institution, physician group, dental group or clinic based either on a full time or part time salary shall not be entitled to direct payment from the department for services rendered to Title XIX recipients.

(e) The department shall reimburse dental providers enrolled in the Connecticut Medical Assistance Program for services provided to members by dental residents or dental students working under the supervision of a licensed dentist.

(f) The department or its designee may refer a member for an evaluation or radiographically or clinically evaluate any dental procedure or treatment provided to the member to ensure the appropriate treatment was performed in accordance with the prevailing standard of care. The department may recoup the fee rendered for any service that was not performed or if substandard care was rendered to a member.

(NEW) Sec. 17b-262-1016. Billing

(a) All dental services performed on behalf of members that do not require prior authorization or post procedure review shall be recorded in the member's permanent record and submitted to the department's claims processing agent either electronically or in hard copy.

(b) The provider shall submit to the department or its designee the amount billed to the department that represents the provider's usual and customary charge for the services delivered.

(c) If the provider does not charge usual and customary fee and retroactive mass adjustment is made, the department shall not compensate a provider for the difference between the adjustment and the fee billed.

(d) Timely Filing for dental claims including orthodontic services shall be 120 days from the date of service.

(NEW) Sec. 17b-262-1017. Marketing Guidelines

(a) All individual dental providers, dental groups, dental clinics, dental facilities or any program or its representatives that provide dental services to CTDHP members shall obtain prior approval from the department or its designee for all marketing activities, health education and any other materials intended to be distributed to CMAP members. Materials that contain outreach information targeting populations being served by the State of Connecticut CMAP, including annual marketing plans and revisions to such plans to recipients of CMAP, including the description of proposed marketing approaches and marketing procedures, are subject to the following guidelines:

(1) The CMAP program logos and names in private marketing materials, targeting recipients of Title XIX and Title XXI programs may be used in conjunction with the provider or the provider's office name only with the approval of the department or its designee;

(2) Any alternative language including non-English translations shall be approved by the department or its designee; and

(3) The font size for the state-wide program phone number shall not be smaller than the font size naming facility or the office phone number.

(b) Corporate marketing that includes the department's programs shall not require prior approval if the corporate marketing exclusively promotes the corporate brand and does not mention any State of Connecticut or departmental programs.

(c) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may not promote their offices through misleading, inaccurate or deceptive electronic, audio, printed or artistic materials characterized by the following:

(1) Inaccurate statements about the nature of an individual's eligibility, enrollment, program benefits, the positive attributes of the office or group or regarding the disadvantages of competing providers, provider groups or facilities;

(2) Misleading or exaggerated claims about the provider, the provider's office or practice group, including any advertisement that its services are free to any state, "Medicaid", "State Insurance", "HUSKY Health" or CTDHP members since prospective members could conclude from the advertisement that only this provider or group provides services or free services to CTDHP members;

(3) False or misleading statements or assertions that any individual dental provider, dental group, dental clinic, dental facility or its representatives is endorsed by the Department of Social Services, the Center for Medicare and Medicaid Services (CMS) or any other governmental entity;and

(4) Deceptive, fraudulent or abusive practices for any purpose including, but not limited to, enticing prospective members to become patients and change their dental home as follows:

(A) Marketing on another network provider's property, inclusive of any commons areas;

(B) Providing transportation services, other than those provided to a member through the CMAP, for the purpose of bringing a member to the provider's office or taking them home from the provider's office; and

(C) Conducting marketing and recruitment activities in state office buildings or outdoor properties.

(d) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may not discriminate against any eligible individual on the basis of race, sex, gender preference**,** age (including pediatric dentistry practices or facilities in the circumstance of older patients who have special cognitive needs), creed, oral health status or the need for future oral health care services.

(e) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives shall not compensate marketing staff, whether they are employees, independent contractors or marketing representatives through the use of a per member/patient incentive or other similar bonus type of reimbursement.

(f) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives shall implement policies and procedures to manage the actions of marketing staff to ensure compliance with all marketing regulations.

(g) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives shall distribute these guidelines to all of its offices and shall require that the guidelines be followed in all offices located in Connecticut or offices which are deemed as "border town" offices or "out of state" practices.

(h) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may display DSS approved materials and brochures in their offices.

(i) All unapproved postings, signage or handouts containing the CTDHP or HUSKY Health endorsements or logos shall be removed pending approval from the department. Failure to remove unapproved marketing materials may result in the suspension of reimbursement for services rendered to members.

(j) The department or its designee shall review materials submitted for approval and respond to review requests from the provider or provider's offices within sixty days from the receipt of the

material. If the department or its designee does not respond to materials submitted for approval within sixty days, the provider, provider group, facility or its representative may use the materials as presented. The department may request revisions or recall any materials that advertise or represent CMAP in advertisements or specific materials at any time.

(k) Recruitment or solicitation of new patients shall be subject to the following limitations:

(1) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may not actively solicit new members at other provider sites, offices, facilities or schools:

(2) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may not distribute materials at DSS eligibility offices, including those in hospitals or other facilities for the purpose of marketing and solicitation;

(3) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives 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 members of CMAP.

(4) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may distribute marketing materials within a 15 mile radius of its office location.

(5) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may not conduct personal, small group or face-to-face marketing activities except as provided in subsection (l) of this section.

(*l*) Recruitment or solicitation of new patients through events:

(1) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may not conduct promotional group meetings or individual solicitation with potential members at:

(A) Other provider offices or group offices;

(B) Private clubs;

(C) Private residences;

(D) Schools; and

(E) Employer sites.

(2) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may conduct outreach or market their services at events and meetings open to the general public including those events held at public facilities, churches, health fairs, other community sites and those organized or sponsored provided that:

(A) The department is notified at least thirty days in advance of the meeting through the submission of a schedule or calendar of educational and marketing events. Schedules and calendars shall contain sufficient information to allow the department or its designee to attend the event and monitor for compliance;

(B) The provider, provider group, clinic or facility utilizes materials approved by the department in its presentation and complies with all marketing guidelines.

(3) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may not collect any personal information, including HIPAA related information, Medicaid identification numbers, names of children or other family members, schools attended, names of employers or places of employment, and the name or location of the member's current dental provider.

(m) Gifts, tokens and incentives to members:

(1) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives shall not under any circumstance request or require personal contact information of potential members in return for any gift item or "free" services;

(2) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may disseminate promotional token gifts of nominal value, such as toothbrushes, sample dental floss, sample toothpastes and rinses, magnets, pens, bags, at approved events and with approved materials to potential members when:

(A) The department or its designee has approved them in advance of their dissemination; and

(B) The unit cost value of each item is less than two dollars and the aggregate cost per potential members shall not knowingly exceed four dollars per occasion.

(3) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may provide the following to members who are patients of record when the department or its designee has approved the items and the criteria for distribution:

(A) Token gifts to members including magnets, phone labels, and other nominal items that promote the dental providers services or to reinforce "good" dental practices or behavior;

(B) "Welcome" packets sent to new patients of record; and

(C) Oral health education materials, including, but not limited to, podcasts, videos, CDs, DVDs and other media.

(4) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives shall not provide or sponsor incentives unless explicitly approved by the department or its designee. Such incentives include, but are not limited to:

(A) Cash, gifts, gift certificates or gift cards to members, patients of record or potential patients;

(B) Gifts of any kind to agencies including the department or its designee, or agencies or stakeholders that hosts meetings with members or potential members;

(C) Raffles in association with marketing related activities or for the purpose of collecting information for future marketing activities for potential members; and

(D) Offering free screenings, examinations or other dental services to potential future patients or soliciting referrals from patients of record.

(n) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may 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.

(o) Individual dental providers, dental groups, dental clinics, dental facilities or their representatives may disseminate professional information which contains no identifying information solely regarding general oral health information materials to their patients of record without prior approval from the department or its designee.

(p) The department or its designee may suspend payments to or disenroll any dental provider, provider group, dental clinic or facility that fails to comply with these regulations.

Statement of Purpose

The purpose of the proposed regulation is to establish, in regulation form, the requirements governing payment of dental services to individuals covered by the Connecticut Medical Assistance programs.

(A) The problems, issues or circumstances that the regulation proposes to address: The current policy, found in the Department's Medical Services Policy Manual is outdated and requires both technical and substantive changes to accurately reflect current policy and practice.

(B) The main provisions of the regulation: 1) Define necessary terms; (2) describe the services covered, service limitations, required provider qualifications and services not covered; (3) describe prior authorization requirements; (4) identify billing and payment rules; (5) describe documentation requirements; and (6) provide guidelines for marketing.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The legal effect of the regulation is to put in regulation form the department's current policies and procedures regarding the payment of dental services provided to members of the Connecticut Medical Assistant Program.