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

Section 1. 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) Airway Evaluation means

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

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

(5) "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;

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

(7) "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;

(8) "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;

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

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

(11) "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;

(12) "Care coordination" means services delivered to an identified patient by a non-dental professional to assist the individual with access to oral healthcare services;

(13) "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;

(14) Central Sleep Apnea is a condition less common and occurs when the brain fails to transmit signals to the muscles of resporation.11 The most common conditions associated with CSA include neurological or neurosurgical conditions (e.g., Arnold-Chiari malformation, brain tumor), genetic conditions (e.g., Down syndrome, Prader-Willi syndrome, achondroplasia), congestive heart failure, stroke, high altitude, and use of certain medications (e. g., narcotics, benzodiazepines, barbiturates).

(15) "Children's Health Insurance Program" or "CHIP" means the federally subsidized program of health care for uninsured, low-income children authorized by Title XXI of the Social Security Act and operated by the department pursuant to sections 17b-289 to 17b-307, inclusive, of the Connecticut General Statutes, also known as HUSKY B;

(16) "CODA" means the Commission on Dental Accreditation;

(17) "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;

(18) "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;

(19) "Comprehensive orthodontic therapy" means the treatment of permanent dentition or facial structures of the craniofacial complex;

(20) "Condylotomy" means the excision of the articulating surface of the mandible;

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

(22) "Connecticut Medical Assistance Program" or "CMAP" means all 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;

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

(24) "Cosmetic dentistry" means employing several different dental procedures singularly or in concert with each other 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;

(25) "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;

(26) "Dental home" means a dentist that provides comprehensive care, including, but not limited to preventive, restorative, periodontal, endodontic, prosthetic, oral and maxillofacial surgery and emergency services, to the member. The Dental Home also has a plan to assist a member after hours in the event an emergency arises and refers patients to appropriate dental specialists for advanced care needs;

(27) "Dental hygienist" means an individual who holds a license issued under sections 20-126h to 20-126w, inclusive, of the Connecticut General Statutes;

(28) "Dental services" means any service provided by a dentist or a dental hygienist or under the direct or indirect supervision of a licensed dentist;

(29) "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;

(30) "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;

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

(32) "Durable medical equipment" (DME) is equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of an illness or injury and is used in the home; Obstructive Sleep Apnea appliances are categorized as DME.

(33) "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;

(34) "Emergency" means a dental condition manifesting itself in acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate dental attention could result in placing the health of the individual, or with respect to a pregnant woman, her unborn child, in serious jeopardy, cause serious impairment to bodily functions or cause serious dysfunction of any body organ or part;

(35) "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 periarticular structures of the tooth;

(36) "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;

(37) "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;

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

(39) "Fixed location" has the same meaning as provided in section 17b-282f of the Connecticut General Statutes;

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

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

(42) "Genioplasty" means the surgical process employed to reshape gingival tissue;

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

(44) "Guided enamel regeneration" or "GER" means a material that contains a self-assembling peptide that regenerates weakened tooth structure that rebuilds enamel by replicating the molecular mechanism of natural enamel formation;

(45) "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;

(46) "Implant supported overdenture" means a complete or removable partial denture that has one or more implants to provide support to the prosthesis in the maxillae or mandible;

(47) "Limited orthodontic therapy" means the treatment of teeth in the transitional or permanent dentition stage and the developing facial structures to alleviate or reduce severity of abnormalities of the craniofacial complex later in life;

(48) "Marketing" means any communication from a provider to a Medicaid or CHIP member that can reasonably be interpreted as intended to influence the member's choice of provider;

(49) "Marketing materials" means materials produced in any medium designed or intended to be provided to Medicaid or CHIP members or the member's parent or legal representative. Materials relating to the prevention, diagnosis, or treatment of a medical or dental condition are not marketing materials;

(50) "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;

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

(52) "Member" has the same meaning as provided in section 290 of the Connecticut General Statutes;

(53) "Mobile dental clinic" has the same meaning as provided in section 17b-282f of the Connecticut General Statutes;

(54) "Obstructive Sleep Airway or Apnea" is a disorder of breathing characterized by episodes of complete or partial upper airway obstruction during sleep, often resulting in gas exchange abnormalities and arousals that cause disrupted sleep patterns.

(55) "Occlusal guards" means a removable hard acrylic or soft dental laboratory processed appliance that is designed to minimize the effects of tooth grinding and clenching, or other occlusal factors including the treatment of temporomandibular joint disease in symptomatic patients;

(56) "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;

(57) "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;

(58) "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;

(59 "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;

(60) "Periodontal services" means the procedures used to treat diseases of the surrounding and supporting structures of the teeth;

(61) "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;

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

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

(64) "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. A pediatric dentist can be considered a primary care dentist for infants and children through adolescence;

(65) "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;

(66) "Prior authorization" means 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;

(67) "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. Procedures subject to review shall include, but not be limited to, those procedures which are performed on an emergency or urgent basis;

(68) "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 or the American Association of Pediatric Dentistry. Prophylaxis shall include the review of dietary standards for foods and beverages containing sugar and oral-hygiene instruction;

(69) "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;

(70) "Public health facility" has the same meaning as provided in section 20-126*l* of the Connecticut General Statutes;

(71) "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 a public health facility;

(72) "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;

(73) "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;

(74) Restrictive Anterior Occlusal Guidance is the condition where there is not enough room to allow the anterior teeth to function in normal lateral and protrusive movements.

(75) "School-based health center" or "SBHC" has the same meaning as provided in section 19a-6r of the Connecticut General Statutes;

(76) "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;

(77) Sleep Apnea Device –are DME devices that are designed specifically for a patient (custom made) to reduce or eliminate sleep apnea and can be intra- oral or extra-oral devices.

(A) Intraoral devices include but are not limited to mandibular advancement devices; tongue retaining devices; hypoglossal nerve stimulator

(B) Extra-oral devices suchs as positive airway flow; Continuous Positive Airway Pressure masks (CPAP)

(78) "Specialist" means 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:

(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) Periodontology 1223P0300X
(J) Prosthodontics 1223P0700X;
(K) Public Health Dentist 1223D001X; and
(L) **General Dentist** 1224G001X;

(79) "Specialty practice" means a practice that holds itself out as a specialty practice, offers selective dental services concurrent with a dental specialty, or has an interest area in general dentistry recognized by the ADA. The dentist must have obtained a degree or certificate in the 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, orthodontic, pediatric, periodontic or prosthodontic services;

(80) "Teeth" are 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;

(81) "Tomosynthesis" means an imaging modality that uses a fixed array of carbon nanotube enabled x-ray sources to produce a series of projections from which three-dimensional information can be reconstructed and displayed;

(82) "Tooth surfaces" are described 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) Occlusal (O) - of the posterior teeth;

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

(84) "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;

(85) "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;

(86) "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;

(87) "Vestibulopathy" 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 enrollment agreement;

(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 dental services that is within a twenty-mile radius of the patient base 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 shall:

(1) Have or contract with a fixed location where a Connecticut Medicaid enrolled licensed dentist pursuant to section 17b-282f of the Connecticut General Statutes;

(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 not more than thirty miles from the associated dentist's fixed dental location, except that a mobile dental clinic located 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;

(4) Review each member's service history before rendering treatment, if available. If the member has a dental home, the mobile clinic shall consult with the dentist of record before providing 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 coordination of care with the member's dental home.

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

(C) The permission may include a list of procedures that may be provided at the mobile dental clinic and shall include the option for the parent or guardian to opt out of certain procedures.

(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 is required pursuant to section 17b-282f of the Connecticut General Statutes to have a contract with a fixed location. The key features of such contract are as follows:

(A) The fixed location shall be a Medicaid enrolled provider.

(B) The fixed location 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 the same services the patient would receive if the members were being served at the fixed location.

(E) All patient records shall be placed in or available electronically to the fixed location not more than five business days following the provision of dental services in the mobile clinic.

(e) School-Based Health Centers shall:

(1) 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 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

(C)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.

(2) 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;

(3) Refer members into comprehensive dental care for services such as restorations, endodontic treatment, or extractions;

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

(5) Have all written materials available in oral and written form in languages other than English as required by 45 CFR 92.101.

(6) Shall 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 the receipt of the request.

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

Payments for dental services shall be made available to CMAP providers for members enrolled in the CMAP.

(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 quality management program(s).

(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, or the office environment rendered by providers.

(j) The ASO may require a dentist or dental hygienist to evaluate the appropriateness, quality and type of care rendered.

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

Non-exhaustive coverage for dental services and limitations to such services are set forth in subsections (a) through (j), subject to the exception process through prior authorization set forth in subsections (k) and (l) and Section 17b-262-1014.

(a) The department covers the following adjunctive services:

(1) General anesthesia and moderate sedation administered by a dentist or oral and maxillofacial surgeon, who holds a valid General Anesthesia or Moderate 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 any members under the age of twelve or members who have a behavioral or cognitive condition which prevents them from receiving care safely;

(B) For use with members undergoing in office oral surgical procedure(s) where sedation is required to perform the procedure;

(D) For the extraction of five or more teeth, or removal of a tooth which fails to become adequately anesthetized using local anesthesia;

(E) For the extraction of third molars if removal of the third molars is medically necessary **and all four third molars are being removed during one procedure; and**

(F) 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) documentation of the reasons of medical necessity and the condition of the tooth/teeth;

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

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

(v) staff members present and the party responsible for monitoring the vital signs;and

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

(2) Inhalation of nitrous oxide for members of any age who have a diagnosis of a documented behavioral health, cognitive disorder or medical condition(s) which supports the need for behavior management related to the dental procedures to be delivered, provided that:

(A) Techniques are employed in conjunction with the delivery of dental services to individuals to help to facilitate a safe environment and reduce dental anxiety;

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

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

(ii) If the member 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 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.

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

(A) Cartnation provided by care coordinators 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 or dental condition.

(5) **Home or facility visits, one time per home or facility per member 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 **custom made** 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 disturbances related to airway pathology as documented by **examination and** a sleep study. All follow-up care but not limited to appliance adjustments shall be included in the payment for this service. **The CMAP dental provider must enroll as a DME provider to deliver sleep apenea and/or airway obstruction devices.**

(9) Palliative Treatment of Dental Pain with documentation and post procedure review.

(b) The department covers the following diagnostic services:

(1) Oral Examinations:

(A) One initial comprehensive oral examination per member per provider and performed by a general or pediatric dentist or prosthodontist. The examination shall include the taking of the medical history, vital signs, the thorough evaluation and recording of the state of both intra-oral and extra-oral hard and soft tissue findings resulting in a new treatment plan for the member. The department may authorize a second comprehensive oral examination only when the member has experienced a lapse in treatment of one and a half years or more and such lapse is documented in the member's treatment record;

(B) One Comprehensive Periodontal Examination per lifetime for patients who are showing signs and symptoms of periodontal disease and includes an evaluation of the periodontal conditions, probing depths and complete charting, evaluation for oral cancer(s), evaluation of the salivary system, the member's medical and dental history, and general health assessment. Caries and restorations must be noted and the condition of the restorations provided.

(C) One detailed and extensive examination per member per provider and performed by an anesthesiologist, endodontist, oral medicine specialist, orofacial pain specialist, oral and maxillofacial surgeon, orthodontist, pathologist, periodontist, or radiologist per provider per year;

(D) 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;

(E) One periodic oral exam for members over the age of twenty-one unless dental or medically necessary to obtain additional periodic examinations;

(F) Additional periodic examinations prior authorized for reasons of dental or medical necessity;

(G) A problem focused oral examination performed by a dentist, four times per member per provider 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 and is limited to four occurrences per member per year;

(H) A screening examination performed by a public health hygienist, two times per member per every twelve-month period, consistent with the following requirements:

(i) The screening examination results shall be documented on the department's "Screening for Oral Health" form and placed in the patient's electronic health record or chart; and

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

(J) A screening examination performed by a physician, physician assistant or nurse practitioner, one time per member during well-child visits with the following requirements:

(i) The findings must be documented in the patient's medical record; and

(ii) The member must be referred for care coordination or to a dental home if oral disease is found.

(I) An orthodontic screening examination limited to two times per member per lifetime.

(2) Diagnostic imaging 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 shall 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 of images needed to diagnose a member's condition, shall be correctly mounted, accurately recorded with the date on which the images were taken and clearly identify the patient's right and left sides, and shall be of diagnostic quality for the department to reimburse the provider. All radiographic images shall have a reason documented in the chart as to why the radiograph was taken including any pathologies found on the image. The department shall cover the following:

(A) One set of horizontal or vertical, intraoral or extraoral bitewing images or tomosynthesis images per member in a twelve-month period as follows:

(i) 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;

(ii) No more than four bitewing or tomosynthesis images may be taken per visit; and

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

(B) One pre-operative cephalometric image per member per orthodontic and oral surgical providers for orthodontic cases and for 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 need for reconstruction.

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

(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 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.

(E) 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.

(F) 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 experienced trauma or have dento-facial anomalies.

(G) A panoramic image one time per three-year period per member per dental home or oral and maxillofacial surgeon or oral radiologist or oral pathologist or orthodontist 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 shall have the right and left sides clearly identified.

(H) One initial periapical or tomosynthesis image and up to three additional tomosynthesis or images annually per member or four periapical or tomosynthesis images 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 periapical or tomosynthesis images are taken over multiple visits to constitute a complete series; and

(iii) If two or more periapical or tomosynthesis images are taken on the same day, the first periapical shall be coded as the first periapical image by each provider and subsequent periapical images shall be coded as additional periapical images regardless of the tooth number by each provider.

(I) Temporomandibular 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, or carious dentin for the evaluation and determination of the relative risk rate of future caries development for children.

(4) Diagnostic casts or digital models are covered at one set per member per provider. Oral surgeons and orthodontists are allowed two sets of diagnostic casts or digital models per member.

(c) The department covers the following endodontic services:

(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 is available for members over the age of twenty-one with the exception of third molars. There shall be no active periodontal disease, at least 75% 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 75% 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 75% alveolar bone remaining, no subgingival decay and there is no active periodontal disease. An adequate tooth structure shall remain to restore the tooth to form and function.

(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 75% alveolar bone remaining and there is no active periodontal disease. An adequate tooth structure shall remain to restore the tooth to form and function; and

(B) For members over the age of twenty-one when the prognosis is favorable, no sub –gingival decay is present, there is at least 75% alveolar bone remaining and there is no active periodontal disease. An adequate tooth structure shall remain to restore the tooth to form and function.

(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 75% alveolar bone remaining and an adequate tooth structure shall remain to restore the tooth to form and function; and

(B) For members over the age of twenty-one when there is no active periodontal disease, no sub – gingival decay, at least 75% alveolar bone remaining and an adequate tooth structure shall remain to restore the tooth to form and function.

(6) The department requires that all endodontic therapy as described in this subsection is documented with pre and post treatment radiographs. The department requires post procedure review for endodontic therapy procedures on permanent dentition and described in the subsection for all providers except for endodontists. The department also requires the following depending on the age of the member and the type of endodontic treatment provided:

(A) For members under the age of twenty-one who receive anterior endodontic therapy or premolar endodontic therapy:

(i) Immediate restoration for the tooth that is endodontically treated if there is no periapical pathology remaining; and

(ii) Postponement of final or definitive restoration until the growth phase of development is completed.

(B) For members over the age of twenty-one who receive anterior endodontic therapy, premolar endodontic therapy or molar endodontic therapy, there shall be an immediate restoration of the tooth endodontically treated.

(7) Direct pulp cap for members under the age of twenty-one including all bases and liners.

(8) Indirect pulp cap for members under the age of twenty-one including all bases and liners.

(9) Obturation or canal preparation for the retreatment for each canal of a previously endodontically treated tooth for members.

(10) Pulpotomy for members under the age of twenty-one where the vitality must be maintained, provided that the primary tooth that has been treated by a pulpotomy is restored with a crown restoration.

(11) Retreatment of previous root canal therapy for child and adult members one time per tooth per lifetime, provided that the need for retreatment will be documented radiographically with a periapical or tomosynthesis image and post – operatively of diagnostic quality.

(d) The department covers the following oral and maxillofacial surgery services:

(1) Alveoloplasty when two or more contiguous teeth are extracted.

(2) Arthrcentesis procedures.

(3) Biopsies of soft and hard tissues.

(4) Bonding device (ligation) to facilitate eruption of an impacted tooth.

(5) Bone grafting when performed in conjunction with a surgical procedure.

(6) Fracture reduction.

(7) Implants to replace multiple congenital missing teeth excluding lateral incisors or to retain denture prosthesis where not enough bone exists to provide a stable base for the denture prosthesis.

(8) Non-surgical exodontia.

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

(A) Acute traumatic injury and post-surgical sequelae 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 lip and/or 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;

(iii) Hemifacial microsomia;

(iv) Treachers Collins Syndrome; and

(v) Crouzon's Syndrome.

(10) Orthognathic surgery only when it has been approved by the department or its designee 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:

(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 causing pain 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 or custom labotory constructed intraoral devices** 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 six months or longer, a low body mass index and low serum albumin related to malnutrition.

(11) Reimplantation of an anterior tooth or teeth.

(12) Ridge augmentation.

(13) Surgical access or ligation of an unerupted tooth for members under the age of twenty-one.

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

(15) Surgical treatment of dentofacial abnormalities, trauma, or diseased states.

(16) Condylotomy or cricoidectomy.

(17) Reconstruction of the temporomandibular joint and/or associated anatomical components.

(18) Mass, hard or soft tissue removal.

(19) Closed reduction of fracture(s).

(20) Open reduction, internal fixation of fractures.

(21) Oro-facial reconstruction; or

(22) Temporomandibular joint surgery.

(23) Surgical placement or removal of temporary anchorage devices.

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

(25) Vestibulopathy to create a stable ridge for denture prostheses.

(e) The department covers the following limited orthodontic therapy:

(1) Orthodontic appliance therapy is covered with prior authorization for members under twenty-one years of age.

(2) For interceptive orthodontic purposes with documentation, including a description of the condition, the type of interceptive orthodontics proposed, length of treatment, models, radiographs, and photographs, demonstrates the need to correct dentofacial conditions using:

(A) Fixed or removable space maintainers;

(B) Corrective spacing deficiency devices used to influence the development phase of upper or lower jaw growth;

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

(D) Retainers for each arch will only be replaced one time per lifetime per member regardless of the reason.

(f) The department covers comprehensive orthodontic therapy:

(1) With prior authorization for members up to the age of twenty-one by a licensed orthodontist, pediatric dentist or general dentist who is qualified to treat orthodontic cases. Records shall be submitted for prior authorization and includes, but is not limited to, color facial photographs on photographic paper, panoramic and cephalometric imaging, diagnostic casts and if necessary, a letter by a licensed professional attesting to an adverse psychological event or outcome due to the malocclusion. The orthodontic case fee includes the first set of maxillary and mandibular retainers.

To qualify for orthodontic therapy:

(A)Members shall be free from active gingivitis or untreated decay and score a twenty-six or greater on a correctly scored Salzmann Assessment Record; or

(B) If the member does not achieve twenty-six points on the Salzmann Assessment Record but is undergoing continuous therapy for six months or greater by a physician, a licensed psychologist, licensed clinical social worker, independent licensed practitioner, family counselor or other recognized and licensed specialist who attests the treatment of the malocclusion will significantly ameliorate the psychological condition(s) caused by the malocclusion.

(2) If the member has one of the following congenital conditions:

(A) Cleft palate or history of a treated bony cleft palate;

(B) Impacted anterior teeth (incisors and/or canines);

(C) Congenitally missing teeth that will be prosthetically replaced, excluding premolar teeth;

(D) Deep impinging overbite with soft tissue impaction causing severe tissue damage which is demonstrated by laceration or attachment loss;

(E) Anterior or posterior crossbite or both of 3 or more teeth per arch;

(F) Overjet greater than 9 mm or a Reverse overjet of .3.5 mm;

(G) When the mandible or maxillae or both or when the dentition, are significantly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology; or

(H) Syndromic craniofacial conditions or conditions which effect the development of teeth.

(3) For members over the age of twenty-one only when there are untreated congenital conditions, facial forms of cancer or trauma, or surgical facial reconstruction is required.

(g) The department covers the following periodontal services:

(1) Periodontal therapy for members under the age of twenty-one as part of Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) services.

(2) Periodontal scaling and root planning therapy for all members who have diabetes, end stage renal disease, will have or have had heart valve procedures, infection of the heart valves, undergone chemotherapy, radiation therapy to the head and neck or stem cell or organ transplantation and on medications for epilepsy.

(3) Periodontal scaling and root planning therapy for treatment of quadrants with three or more contiguous teeth when medically necessary.

(4) Periodontal scaling and root planning therapy may not be performed in conjunction with prophylaxis or extraction of teeth or other surgical procedures.

(5) Covered non-surgical procedures include:

(A) Full mouth debridement for all members to facilitate evaluation limited to one time per member per provider per year with prior authorization;

i) Prior authorization documentation required is a Comprehensive Periodontal Evaluation with a complete radiographic series(panoramic radiographs are not acceptable), photographic documentation of the oral cavityand a comprehensive phased treatment plan specific to the member.

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

(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 medically necessary.

(D) Scaling and root planning of the root surfaces and crowns of teeth limited to one time per quadrant per three-year period for members over the age of twenty-one with identified chronic disease conditions when medically necessary. Full oral and periodontal charting and assessments and diagnostic imaging are required as part of the documentation including pocket depths and, intraoral photographs and medical necessity documentation. The documentation must state the quadrants to be treated and the procedure to be prior authorized.

(6) 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 and full oral and periodontal charting including pocket depths documented and prior authorization **as part of EPSDT requirements.**

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

(8) Members who are eligible and require periodontal services shall review and sign the department's form, "Periodontal Therapy" and placed in the member's chart as part of the permanent record.

(h) The department covers the following preventive services:

(1) **Custom laboratory made a**thletic 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 and clearly documented in the member's chart. 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, one time per every six-month period, or in conjunction with dental prophylaxis.

(4) Additional fluoride treatments with prior authorization when:

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

(B) the member has a significant cognitive impairment;

(C) the Member has a chronic medical condition placing him or her at higher risk for decay;

(D) the member has undergone or is currently on intravenous, parenteral or oral bisphosphonate or similar therapy;

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

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

(G) the member has a debilitating illness where the recipient cannot maintain proper oral hygiene; or

(H) the member is at higher risk for decay as determined by the Caries Risk Assessment.

(4) Silver Diamine Fluoride (SDF) used as a caries arresting medicament or as a topical fluoride treatment for children and adults as recommended by the American Academy of Pediatric Dentistry and American Dental Association respectively as the prevailing standard of care.

(5) Custom fluoride trays one time every two years for members under the age of twenty-one with a documented need and for Members over the age of twenty-one with prior authorization for reasons

of medical necessity.

(6) Prophylaxis:

(A) For members under the age of twenty-one, one time every six months or more if prior authorized; and

(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. Members with predetermined medical conditions may be pre-approved for a cleaning two times per year.

(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 years.

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

(A) Teeth 2, 3, 14, 15, 18, 19, 30 & 32 are candidates for sealant placement. Teeth shall be free from decay or determined by the provider that the sealant will arrest decay and shall have erupted sufficiently so proper isolation can be achieved for sealant placement.

(B) Sealant placement shall be reimbursed on a per tooth basis and includes 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 twenty-one;

(ii) On second molar teeth from the age eleven to twenty-one;

(iii) Primary dentition 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.

(i) The department covers the following prosthodontic services:

(1) Complete and removable partial dentures provided for functional purposes that are constructed by any dentist require prior authorization and are subject to the following:

(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; and

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

(2) Replacement dentures one time in each seven-year period regardless of the reason and subject to the following:

(A) Replacement dentures shall not be approved if lost within the first year of placement regardless of the reason for the loss except for in the case of a catastrophic reason for the loss;

(B) 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;

(C) 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;

(D) 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;

(E) Replacement denture prosthesis shall only be considered for purposes of mastication, excluding replacement for the reasons of cosmetics and phonation. The department requires medical documentation from the member's dentist or physician provides establishing the member's medical need for the requested treatment in accordance with the definition of medical necessity in subsection (a) of section 17b-259b of the Connecticut General Statutes; and

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

(3) Removable partial dentures are covered when the member is missing an anterior tooth or teeth or does not have an adequate number of posterior teeth in functional occlusion for mastication and are subject to the following:

(A) Teeth with sixty percent or greater bone loss shall be included in the partial denture prosthesis;

(B) The member shall have at least two stable abutment teeth;

(C) In the absence of qualifying posterior missing teeth, the member may have one or more missing anterior teeth;

(D) When both maxillary and mandibular dentures are requested, there must be teeth missing bilaterally in both arches;

(E) Unilateral removable partial dentures are covered if a member is missing posterior teeth in one quadrant and missing posterior teeth in the opposite arch and quadrant resulting in a lack of an adequate surface area for mastication;

(F) If a member requires a complete denture within the first two years of placement of a partial denture(s) by the same provider, the money for the partial denture shall be recouped; and

(G) All preventive, restorative and endodontic procedures shall be completed prior to requesting prior authorization and before constructing the partial denture(s).

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

(5) 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; and

(C) If a member fails to receive and accept the final removable or complete denture(s) and the provider has made at least three attempts to contact the Member, the provider may submit for reimbursement of the laboratory bill which must include the laboratory's invoice.

(6) 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) A direct or indirect reline or rebase of denture prosthesis six months after post-denture prosthesis delivery.

(B) Direct reline office procedures one time per prosthesis every twelve months: and

(C) Indirect processed procedures every twelve months.

(7) Fixed acid-etched partial dentures for members under the age of twenty-one who have congenitally missed 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 gingivitis or 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 daily.

(8) Implant supported overdentures.

(9) Implants if member has had facial trauma; 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 facial prosthesis.

(A) May be covered when there is not enough alveolar ridge to support a denture with medical necessity documentation, intraoral photographs, diagnostic imaging and diagnostic casts are submitted for prior authorization; and

(B) May be covered for members under the age of twenty-one for missing anterior teeth with reasons of medical necessity.

(j) The department covers the following restorative services:

(1) Amalgam, composite or glass ionomer 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 and are subject to the following:

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

(B) More than one amalgam, composite or glass ionomer 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, composite or glass ionomer 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 and:

(i) On the first permanent maxillary molars (teeth numbers 3 and 14), the distinction is limited to the occlusal-lingual surfaces; and

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

(E) Glass ionomers may be used in lieu of composite resin when placed on root surfaces of teeth if the member has a high rate of decay or is unable to maintain oral hygiene;

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

(F) Amalgam and composite resin restorations are expected to last a minimum of five years and may be recouped if determined to be at an unacceptable level and of poor quality or inappropriately placed.

(2) Composite resin infiltration of incipient lesions.

(3) Guided enamel restorative regeneration.

(4) Artificial permanent crowns:

(A) For 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 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;

(C) For 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; and

(D) Crown types covered include:

(i) Cast Crowns on all permanent teeth;

(ii) Ceramic/Zirconia crowns on all teeth;

(iii) Milled crowns which follow the regulations for crowns on teeth;

(iv) Porcelain fused to metal crowns on all permanent teeth;

(v) 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 still crown; and

(vi) Aesthetic coated stainless - steel crowns for primary teeth.

(3) Indirect placed onlays with prior authorization.

(4) 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.

(5) Guided enamel regeneration: A method used to treat initial signs of tooth decay.

(6) Pin retention.

7) Sedative filling for vital teeth two times per tooth per year.

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

(9) Replacement of a stainless-steel crown or zirconia crown in the primary dentition shall be 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.

(10) Replacement of a lost crown on a permanent tooth will be reimbursed after a three-year period has lapsed by the same provider.

(k) Notwithstanding subsections (a) through (j) above, a type of non-experimental dental service not listed above or limited above to situations not including an individual member's particular situation may be authorized through the prior authorization process where the member's dentist or physician provides required medical documentation establishing the member's medical need for the requested treatment in accordance with the definition of medical necessity in subsection (a) of section 17b-259b of the Connecticut General Statutes.

(l) Notwithstanding subsections (a) through (j) above, a numerical or frequency limitation on a type of dental service shall not be applied in instances where the member's dentist or physician through the prior authorization process provides medical documentation establishing the member's medical need for

the quantity or frequency in accordance with the definition of medical necessity in subsection (a) of section 17b-259b of the Connecticut General Statutes.

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

The following services are not covered by the CMAP:

(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 five teeth except for 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 or tomosynthesis diagnostic imaging performed on the same date of service as a complete or tomosynthesis or full mouth series.

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

(3) Periapical or tomosynthesis diagnostic imaging taken for general or screening purposes unless infection, trauma or a developmental abnormality is suspected and is documented in the patient's chart.

(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.

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

(c) Endodontic Services:

(1) Apexogenesis for members over the age of eighteen.

(2) Endodontic services are not covered for a tooth where the member expects to receive a removable partial denture replacing multiple teeth in the same arch unless the tooth is functioning as a rest.

(3) Third molars are not covered unless the tooth or teeth will function as a rest for a partial denture.

(4) Pulpotomy on a primary tooth nearing exfoliation when periradicular pathology extends into the underlying developing tooth bud (the tooth is non-vital) and if excessive internal root resorption has occurred or the pulp floor naturally or iatrogenically opens into the bifurcation.

(5) Pulpotomy for a permanent tooth by the same provider that is expecting to perform complete root canal therapy within one year period after the pulpotomy has been performed.

(d) Oral Surgical Services:

(1) Alveoloplasty in conjunction with single or singular extractions.

(2) Brush biopsy.

(3) Cosmetic surgical services.

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

(5) Orthognathic surgery for members over the age of 30 who do not have a severely handicapping malocclusion score of greater than 50 on the Salzmann Handicapping Malocclusion Index.

(6) 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.

(7) 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.

(8) 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.

(5) Periodontal therapy without obtaining prior authorization.

(f) Preventive Services:

(1) Counseling or education services.

(2) Nutritional counselling unless performed by a registered dietitian or licensed nutritionist.

(3) Habit breaking devices unless orthodontic prior authorization is requested.

(4) Removable unilateral space maintainers.

(5) Space maintainers for anterior teeth.

(6) Space maintainers in conjunction with active orthodontic therapy.

(7) Toothbrush prophylaxis.

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

(g) Prosthodontic Services:

(1) Cosmetic dentistry.

(2) Fixed conventional partial dentures (Bridges).

(3) Immediate dentures.

(4) Implant placement for the replacement of teeth that are lost due to dental disease(s).

(5) Routine implant placement for the replacement of single or multiple teeth lost unless significant congenital abnormalities, surgical reconstruction or traumatic situations exist.

(6) Implant placement for congenitally missing lateral incisors.

(7) Indirect labile veneers.

(8) Nesbit partial dentures.

(9) Office visits to obtain a prescription where the need for such prescription has already been ascertained.

(10) Complete or partial removable dentures for members who are in a semi-conscious or unconscious state.

(h) Restorative Services:

(1) Procedures performed for purely cosmetic or aesthetic reasons.

(2) Coping restorations.

(3) Gold foil restorations.
(4) Direct or indirect inlays.
(5) Indirect labial veneers.
(6) Unilateral removable appliances for one arch.
(7) Placement of an indirect pulp cap.
(8) Procedures to teeth nearing exfoliation or to teeth that are non-restorable.
(9) Procedures to teeth with less than 75 % bone support or significant periodontal involvement.
(10) Any procedure, service or goods not explicitly allowed pursuant to section 17b-262-866 of the Regulations of Connecticut State Agencies.

(i) 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 to undergo as a private pay patient. The provider shall 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.

(j) Any non-experimental procedure or service which is not listed on the dental fee schedule shall not be covered unless the provider submits a request for prior authorization pursuant to § 17b-262-1014 and provides required medical documentation establishing the member's medical need for the requested service in accordance with the definition of medical necessity set forth in subsection (a) of section 17b-259b of the Connecticut General Statutes.

(k) Any procedure that has been attempted but not completed.

(l) Any procedure that is an upgrade to the Medicaid covered procedure where the member is balanced billed for the difference.

(m) Any service divided into smaller components of treatment that is by common definition and standards of care included in a single CDT code.

(n) Unbundling of a group of procedures normally performed in a single visit as is the standard of care.

(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 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.

(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 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 numbers;
(16) 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;
(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 provided this is consistent with these regulations and subject to the definition of medical necessity set forth in subsection (a) of section 17b-259b of the Connecticut General Statutes. 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 electronically or printed on photographic paper;
(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 CMAP.

(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.

(g) Any member denied prior authorization, in whole or in part, for any reason shall be provided a written notice explaining the action and advising of the right to appeal such action through requesting an administrative hearing with the department in accordance with section 17b-60 of the Connecticut General Statutes.

(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 CMAP 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 fees 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) Prohibited marketing activities. Any dental provider, including a dentist, dental clinic, mobile dental clinics and SBHCs, participating in the CMAP shall not engage in any marketing activity, including any dissemination of material or other attempt to communicate, that:

(1) Involves unsolicited personal contact, including by door-to-door solicitation, solicitation at a childcare facility or other type of facility, direct mail, or telephone, with a Medicaid member or a parent whose child is enrolled in the CMAP;

(2) Is directed at the member or parent solely because the member or the parent's child is receiving benefits under the CMAP; and

(3) Is intended to influence the member's or parent's choice of provider.

(b) Permissible marketing activities by dental providers participating in the CMAP. Nothing in this rule prohibits a dental provider participating in the CMAP from:

(1) Engaging in a marketing activity, including any dissemination of material or other attempt to communicate, that is intended to influence the choice of provider by a Medicaid client or a parent whose child is enrolled in the Medicaid program, if the marketing activity:

(A) Is conducted at a community-sponsored educational event, health fair, outreach activity, or other similar community or nonprofit event in which the provider participates and does not involve unsolicited personal contact or promotion of the provider's practice that is not used as part of health education; or

(B) Involves only the general dissemination of information, including by television, radio, newspaper, or billboard advertisement, and does not involve unsolicited personal contact.

(2) As permitted under the dental provider's contract, engaging in the dissemination of material or another attempt to communicate with a Medicaid member or a parent whose child is enrolled in the CMAP, including communication in person or by direct mail or telephone, for the purpose of:

(A) Providing an appointment reminder;

(B) Distributing promotional health materials;

(C) Providing information about the types of services offered by the provider; or

(D) Coordinating patient care.

(3) Engaging in a marketing activity that has been submitted for review and obtained a notice of prior authorization from the Department under subsection (c) of this section.

(c) Review and prior authorization. A dental provider participating in the CMAP may submit proposed marketing materials to the department for review and prior authorization to ensure that the materials are in compliance with this rule. The department may grant or deny a provider's request for prior authorization in accordance with the following:

(1) The department 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;

(2) 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; a n d

(3) The department may request revisions or recall any materials that advertise or represent CMAP in advertisements or specific materials at any time.

Section 2. Section 17-134d-35 of the Regulations of Connecticut State Agencies is repealed.

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 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.