Connecticut Medical Assistance Program Provider Bulletin 2017-81
Policy Transmittal 2017-29 December 2017

Roderick L. Bremby, Commissioner

Effective Date: January 1, 2018
Contact: Donna Balaski, DMD @ 860 424–5342

TO: All Dental Providers
RE: Annual Dental Benefit Maximum

The purpose of this policy transmittal is to notify dental providers that for dates of service January 1, 2018 and forward, there will be changes to the dental program. Pursuant to Public Act 17-2, Sec. 49 (June 2017 Special Session), an annual dental benefit maximum of **$1,000** will be implemented for dental services provided to **adult members ages 21 and older.**

Beginning January 1, 2018, the dental benefit accrual will begin for dates of service January 1st through December 31st. The dental benefit accrual will reset on January 1st of each year. The changes apply to dental services reimbursed for members over the age of twenty – one (21) under HUSKY A, C, & D.

Please note that when a member turns 21, the accrual of dental benefits paid will begin with all adjudicated and paid claims on and after their 21st birthday through December 31st of that year.

Member's Accrual toward the Annual Dental Benefit Maximum:

Providers will be able to verify the total of each member's accrual of services towards the annual dental benefit maximum from their secure provider Web Portal at www.ctdssmap.com. DXC Technology will also post the member eligibility and accrual balance information on the Automated Voice Response System (AVRS) accessed by calling 1-800-842-8440. DXC Technology will have the most current accrual as it will contain the daily submitted claims that are due to pay in upcoming claims payment cycles.

The Connecticut Dental Health Partnership (CTDHP) also provides a treatment history listing for **the services that have been adjudicated up to the previous day** at www.ctdhp.com. CTDHP will display a member's dental benefit accrual in the treatment history listing. However, the CTDHP treatment history listing will not be as up to date as the DXC Technology accrual as CTDHP receives claim data on a 24 hour cycle from DXC Technology. Dental providers and members may access the member's treatment history at www.ctdhp.com through the provider portal under "**Provider Partners**".

Each dental office is strongly encouraged to ensure that individual members have not exceeded or will not exceed the maximum limit when providing a dental service at every appointment. It is a shared responsibility of the Department of Social Services (DSS) and each provider office to inform members of their remaining benefit balance. You are encouraged to share the balance remaining with each member as you verify the dental benefit accrual balance and member eligibility.

On occasion, members may have sought care from another provider for dental treatment, and the claim has not been submitted for payment at the time of the member's appointment. Each dental office is strongly

encouraged to inquire from the member as to who their last dental provider was, and when the member last had a dental visit.

Members Who Approach Their Accrual Maximum:

If a member requires dental services that may exceed the annual dental benefit maximum and the provider believes the services are medically necessary, the provider should request prior authorization (PA) for the service(s). The full remaining treatment plan should be submitted including all supporting documentation required to substantiate reasons of medical necessity, including but not limited to radiographs, photographs, written commentary and statements of medical necessity from the member's primary care provider.

Please note that letters of medical necessity from a physician should include, but are not limited to, the member's medical condition(s), the treatment or drugs prescribed to treat the condition(s), description of weight loss (amount and over a specified duration of time), Body Mass Index (BMI) and any physical limitations that a patient may have that justify exception due to medical necessity. All dental providers should review the reason for appropriateness of the medical necessity provided by the physician before submitting the documentation for review.

A determination will be made using all documentation received and the procedures will either be approved or denied. If the services are denied, a Notice of Action (NOA) will be issued to the member and a denial letter sent to the dental office.

Members Who Exceed Their Accrual Maximum:

If a member requires a dental service that will exceed the annual dental benefit maximum, then the service may be prior authorized for reasons of medical necessity.

In the event a member utilizes and exceeds the annual dental benefit maximum without demonstrating medical necessity, then the member may be responsible for the balance if he or she ***knowingly*** elects to receive the service(s) which exceed the annual dental benefit maximum. The member may not be billed unless and until they have signed a form indicating that the proposed service is not covered because it exceeds the maximum, but they are willing to assume responsibility for payment (Section 17b-262-531 Payment Limitations). Such consent shall include a specific financial statement describing the service(s) for which he or she accepts responsibility. A member may also consent to partial payment for a service or procedure, if the remaining accrual amount will cover only part of the cost of the service. Again, this consent must be obtained **before** the procedure(s) is performed.

Services that are excluded from Accrual Maximum

Please note that emergency dental services (Emergency as defined in Sec. 24. Subsection (a) of section 17b-282c and hospital – based surgical procedures) and dentures will **not** be counted towards the annual dental benefit maximum since the dental fee exceeds the dental accrual balance. *All applicable current regulations and limitations apply and the procedures will be approved if the procedures qualify under reasons of medically necessity.*

Submission of Claims to DXC Technology:

All providers are strongly encouraged to submit unpaid claims for processing and payment on a timely basis when procedures are completed and delivered.

All claims for members are processed and are paid based on their submission date; on a first submitted first paid basis**.**

Failure to submit claims on a timely basis could result in non – payment if the member elects to see another provider. All offices should verify the remaining amount of the benefit each member has on the secure provider Web Portal available at www.ctdssmap.com.

Notifying Members of Accrual Balance:

Notification will be sent to each member as they approach their annual dental benefit maximum amount at 90%. After a member exceeds their annual dental benefit maximum amount, he or she will receive a Notice of Action (NOA) listing which services were denied through the PA process because the services were determined not to be medically necessary. Members may access their dental history and accrual balance through the Client Login portal at www.ctdhp.com to view their current dental history and accrual balance.

For services that are medically necessary when the annual dental benefit maximum is reached, the service(s) may be prior authorized. It is important to submit all appropriate documentation at the time of the PA request.

PA requests should be submitted to BeneCare Dental Plans on behalf of the CTDHP. PA requests may be submitted electronically via the www.ctdhp.com provider Web Portal.

To upload a PA request, follow the steps outlined below:

1. Access the www.ctdhp.com Web site and click on **"Provider Partners."**

2. Enter your Billing NPI and Tax ID numbers in the appropriate boxes and click on "**Submit**."

3. A new screen will appear, click on "**Prior Authorization Upload.**"

4. Follow instructions for prior authorization or post procedure review requests.

Hard copy submissions for non-orthodontic services that require PA should be sent to the following address:

Prior Authorization
C/O Bene Care Dental Plans
P.O. Box 40109
Philadelphia, PA 19106-0109

Verifying Prior Authorization Status Electronically

PA approval status may be verified via the CT Medical Assistance Program Web Portal at www.ctdssmap.com. Providers can log onto their secure Web account and access the "Prior Authorization inquiry link" on the right hand side to access the PA Inquiry or select Prior Authorization on the Menu Bar. Providers can search for PA approvals by the client ID if you have not received notification from CTDHP that has the PA number. Providers may also verify the prior authorization approval by entering the letter "B" followed by the PA number provided by CTDHP.

Accessing the Fee Schedules:

The adult and children's dental fee schedules can be accessed and downloaded by logging onto the Connecticut Medical Assistance Program Web site: www.ctdssmap.com.

From this Web page, go to "***Provider***", then to "***Provider Fee Schedule Download***". Click on the "***I accept***" button and proceed to

click on the "***Dental***" fee schedule (Adult or Pediatric). To access the CSV file, press the control key while clicking the CSV link, then select "***Open***".

For questions about billing or if further assistance is needed to access the fee schedule on the Connecticut Medical Assistance Program Web site, please contact the Provider Assistance Center, Monday through Friday from 8:00 a.m. to 5:00 p.m. at 1-800-842-8440.

The Connecticut Dental Health Partnership (CTDHP) posts a copy of the adult and children's fee schedules on their Web site: www.ctdhp.com.

Posting Instructions: Policy transmittals can be downloaded from www.ctdssmap.com.

Distribution: This policy transmittal is being distributed to providers of the Connecticut Medical Assistance Program by DXC Technology.

Responsible Unit: DSS, Division of Health Services, Integrated Care, Dental Unit, Donna Balaski, D.M.D. at (860) 424–5342 or donna.balaski@ct.gov.

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