Connecticut Medical Assistance Program Provider Bulletin 2019-24

Policy Transmittal 2019-09 May 2019

Roderick L. Bremby, Commissioner

Effective Date: January 1, 2018
Contact: Donna Balaski, DMD

TO: All Dental Providers
RE: Annual Dental Benefit Maximum Medical Necessity Threshold

This policy transmittal replaces and clarifies Provider Bulletin 2017-81, dated December 2017 and effective January 1, 2018, relating to the annual benefit maximum for nonemergency dental services for adult HUSKY A, C and D members who are 21 years old and older.

In summary, effective January 1, 2018, and per subsection (a) of section 17b-282c of the Connecticut General Statutes, the Department of Social Services (DSS) covers up to $1,000 per calendar year per adult member for certain nonemergency dental services for the HUSKY A, C & D populations without the dental provider having to first obtain prior authorization (PA) that the services are medically necessary. If the dental provider thinks additional services are medically necessary, he or she must seek PA from DSS before providing them to the member. If DSS agrees that the requested services are medically necessary, DSS will approve the request and pay for the services. If DSS denies the request for PA as not medically necessary, the member may appeal that decision to DSS' hearing office or the member may decide to pay out-of-pocket for the service, as will be described in more detail below.

What Does the Statute Provide?

Per the statute, certain nonemergency dental services (diagnostic, prevention, basic restoration procedures and nonsurgical extraction consistent with standard and reasonable dental practices) are exempt from the DSS' PA process up to a maximum amount of $1,000 per member per calendar year, regardless of the number of dental providers serving the member. DSS may pay for services that exceed the $1,000 threshold if, subject to PA requirements, DSS determines that the services are medically necessary, as defined in section 17b-259b of the Connecticut General Statutes.

Emergency dental services, as defined in subsection (a) of section 17b-282c of the Connecticut General Statutes, hospital-based surgical procedures and dentures are **not** counted toward the annual dental benefit maximum.

How does the Statute Work?

Under Connecticut law, "a provider shall not charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for the cost of goods or services which are covered and payable under the Connecticut Medical Assistance Program." Conn. Agencies Regs. § 17b-262-531(j).

If you think nonemergency dental services are medically necessary for a member, and that payment for such services may exceed the $1,000 limitation for that member, **prior to providing or billing the member for services,** you must seek and obtain PA from the Connecticut Dental Health Partnership (CTDHP), DSS' contractor. *See* Conn.

Agencies Regs. § 17b-232-531(k) ("a provider shall not charge for medical goods or services for which a client would be entitled to have payment made, but for the provider's failure to comply with requirements for payment established by these regulations").

When seeking PA for medical necessity, you must submit the full treatment plan and all documentation, including, but not limited to, radiographs, photographs, written commentary and, as appropriate, statements from the member's primary care provider, to support medical necessity of the proposed dental treatment. For example, if a member has physical limitations, such as excessive weight loss, or uses certain drugs that adversely affect the person's oral cavity, the primary care provider must describe and document medical necessity of the dental treatment in light of these conditions, and the dental provider should review it. If the medical necessity relates to weight loss, the documentation must include the amount of weight loss over the number of months.

If CTDHP agrees that the additional dental treatment is medically necessary for the member, Medicaid will pay the claims for the additional treatment.

If, however, CTDHP denies PA for the requested services as not medically necessary, CTDHP will send the dental provider a denial and the member a Notice of Action (NOA). The NOA will explain that the dental provider's request for payment of additional dental services was denied for lack of medical necessity, and that the member has the right to request a hearing with DSS to appeal that finding. If the member requests a hearing and the hearing officer rules that the services requested in the PA request are medically necessary, DSS will pay for the services.

If the member decides not to appeal CTDHP's decision, the dental provider may ask if the member wants to pay out- of-pocket for the additional services. Under Connecticut law, "a provider shall only charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for goods or services which are not coverable under the Connecticut Medical Assistance Program, when the client knowingly elects to receive the goods or services and enters into an agreement in writing for such goods or services prior to receiving them." Conn. Agencies Regs. § 17b-232-513(l).

You may not perform the service or bill the member unless the member has **knowingly** signed a form/agreement that (1) explains the type of service that is not covered by Medicaid due to lack of medical necessity; (2) details the amount of money the dental provider will charge the member for the service; and (3) confirms that the member understands that he or she is consenting to paying for the services. Again, the provider must obtain this consent **before** performing the procedure(s).

How do I Know How Much Medicaid Has Already Paid for Nonemergency Dental Services for the Member?

Beginning January 1st of each year, this dental benefit accrual begins for dates of service from January 1st through December 31st. The dental benefit accrual resets on January 1st of each year and applies to nonemergency dental services for HUSKY A, C and D members who are 21 years old and older. If a member turns 21 during a calendar year, the accrual of dental benefits paid starts with the member's 21st birthday and goes through December 31st of that year.

DXC Technology will post on its provider Web Portal, www.ctdssmap.com, the total of each member's accrual of services toward the annual dental benefit maximum. Please use

this Web site to determine the most current accrual amount; it reflects not only the amount already paid for the member in the calendar year, but also any amounts that are due to be paid in upcoming claims payment cycles. To access the most current information, once logged in, click on "claim history for specific services" under the "Claims" link. Enter the Client ID, select "Dental Benefit Limit" as the Inquiry Type, enter the Date of Service and click "Search."

At every appointment, prior to performing nonemergency dental services, dental providers must check that members have not and will not exceed the maximum limit. A member may have sought treatment from another provider so you would not be aware that Medicaid had paid for nonemergency dental services for the member, other than the ones you performed. Please share the balance remaining with each member as you verify the dental benefit accrual balance and member eligibility.

DXC Technology will notify members when they have reached 90% of the annual dental benefit.

How Do I Submit Prior Authorization Requests?

Providers must submit PA requests to BeneCare Dental Plans on behalf of CTDHP. They 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 PA or post procedure review requests.

You can also submit a hard copy request for PA to the following address:

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

Can I Find Out Electronically if my Prior Authorization Request is Approved?

Yes. Dental providers can learn the status of a request for PA via the Connecticut Medical Assistance Program Web Portal at www.ctdssmap.com. Once logged in to your secure Web portal account, access the "PA inquiry link" on the right side to access the Prior Authorization Inquiry or select Prior Authorization on the Menu Bar. Providers may verify the PA approval by entering the letter "B" followed by the PA number provided by BeneCare. If you have not received a PA number from BeneCare, you can also search for PA information by using the client ID.

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.

Posting Instructions: Policy transmittals may 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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