



Connecticut interChange MMIS

Provider Manual

**Chapter 7 - Dental
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CONNECTICUT MEDICAL ASSISTANCE PROGRAM
Dental Services Regulation/Policy
Chapter 7

Medical Services Policy

7.1

This section of the Provider Manual contains the Medical Services Policy and Regulations of Connecticut State Agencies pertaining to dental services.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process and sent policy update pages to place in Chapter 7 of their manuals.

Dental Services

Requirements for Payment of Dental Services

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**Requirements for Payment of Public Health Dental Hygienist Services
(Regulations of Connecticut State Agencies)**

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MEDICAL SERVICES POLICY

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184. – 184A.III

184 Dental Services

For the purposes of this section, dental services are diagnostic, preventive, or restorative procedures, performed by a licensed dentist in a private or group practice or in a clinic; a dental hygienist, trained dental assistant or, or other dental professionals employed by the dentist, group practice or clinic, providing such services are performed within the scope of their profession in accordance with State law. These services relate to:

- I. The teeth and other structures of the oral cavity; and
- II. Disease, injury, or impairment of general health only as it relates to the oral health of the recipient.

A. Legal Bases

- I. Code of Federal Regulations: 42 CFR 440.100
- II. Connecticut General Statutes: Section 17b-262
- III. Regulations of Connecticut State Agencies:
Sections 17-134-2(10), 17-134d-35

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184B. - 184B.VII.

B. Definitions

I. Dentist:

“Dentist” means an individual licensed by the State Department of Health Services to practice dentistry or dental surgery.

II. Dental Clinic:

For the purpose of this section, “Dental Clinic” means a clinic not associated with a hospital which has been issued a permit from the Connecticut State Dental Commission to operate a clinic for the purpose of providing diagnostic, preventive, or corrective dental procedures to outpatients. Services are performed by or under the supervision and control of a licensed dentist who assumes the primary responsibility for any dental procedures performed, as limited by State law, by licensed dental hygienists, trained dental assistants or dental students. The dentist need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

III. Dental Services:

“Dental Services” means those services provided by or under the supervision and control of a licensed dentist. The dentist assumes the primary responsibility for any dental procedures performed.

IV. Emergency Service:

“Emergency Service” means a service provided to a recipient for the relief from pain or treatment of infection or injury.

V. Treatment Plan:

“Treatment Plan” means a detailed list of dental services which a patient requires to return to or maintain oral health as determined and recorded in the patient’s file by the dentist.

VI. Dentures:

“Dentures” means artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.

VII. Home:

“Home” means the recipient’s place of residence which includes a boarding home or Home for the Aged. Home does not include a hospital, Skilled Nursing Facility, or Intermediate Care Facility.

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184B.VIII. – 184D.

VIII. Qualified Dentist: Orthodontics

“Qualified Dentist: Orthodontics” means a dentist who:

(a) holds himself out to be an orthodontist in accordance with Section 20-106a of the Connecticut State Statutes,

or

(b) documents completion of an American Dental Association accredited post graduate continuing education course consisting of a minimum of two (2) years of orthodontic seminars, and/or submitting three (3) completed case histories with a comparable degree of difficulty as those cases meeting the Department’s requirements in Section (F) of this manual if requested by the orthodontic consultant.

IX. The Department:

“The Department” means the state Department of Social Services.

X. Preliminary Handicapping Malocclusion Assessment Record (PHMAR):

“Preliminary Handicapping Malocclusion Assessment Record” means the method of determining the degree of malocclusion and eligibility for orthodontic services. Such assessment is completed prior to performing the comprehensive diagnostic assessment.

XI. Comprehensive Diagnostic Assessment (CDA):

“Comprehensive Diagnostic Assessment” means a minimum evaluative tool for an orthodontic case which determines the plan of treatment necessary to correct the malocclusion. The assessment includes, but it is not limited to, the following diagnostic measures: radiographs, full face and profile photographs or color slides.

C. Provider Participation

I. The provider must meet all applicable state licensing and certification requirements.

II. The provider must meet all departmental enrollment requirements.

D. Eligibility

Payment for Dental Services is available for all persons eligible for Medicaid, subject to the conditions and limitations which apply to these services.

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184E. - 184E.I.b.1.

E. Services Covered and Limitations

Except for the limitations and exclusions listed below, the Department will pay for the professional services of a licensed dentist or dental hygienist which conform to accepted methods of diagnosis and treatment, but will not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient's diagnosis, symptoms or medical history.

I. Dental Services Covered and Limitations

a. Diagnostic Services, including

1. Home visits
2. Radiographs
 - (a) Intraoral, complete series (full mouth) consisting of at least ten (10) periapical films plus bitewings, limited to once during any three (3) year period.
 - (b) Bitewing films, only once during any six (6) month interval per provider.
 - (c) Periapical films, but the single first film is not covered on the same date of service as bitewings, panoramic, or lateral jaw films.
3. Oral examinations, available to all Title XIX clients with the following limitations:
 - (a) Initial Oral Exam, includes a complete history work-up and is limited to one per patient in a three year period.
 - (b) Periodic Oral Exam, initiated 6 months subsequent to an Initial Oral Exam and may be utilized every six months thereafter.
 - (c) Emergency Oral Exam, may be used when diagnosing a palliative (emergency) treatment.

b. Preventive Services, subject to the following:

1. Prophylaxis, once every six (6) months per provider.

Prophylaxis includes cleaning, supra and subgingival scaling, and polishing teeth. (Refer to Section I.III.f.)

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184E.1.b.2. - 184E.I.c.2.(c)

2. Fluoride treatment for children under 21 years of age will be paid for no more than twice a year (at 6 month intervals) per provider. Prior authorization is required for recipients 21 years of age and over.
 3. Space maintainers.
 4. Night Guard.
 5. Pit and fissure sealants for children ages 5 through 16, once in a five year period per tooth, limited to first and second permanent molars.
- c. Restorative services, limited to the restoration of carious, permanent, and primary teeth, with
1. Fillings
 - (a) Permanent fillings using silver amalgam or composite resin material are limited to one (1) per year to the same surface by the same provider unless authorized by the dental consultant.
 - (b) Temporary sedative fillings, only when done to treat dental pain requiring emergency treatment.
 - (c) More than one amalgam filling on a single surface will be considered a single filling. Anterior or composite fillings involving more than one surface will be considered as a single filling. Only those fillings involving the incisal corner will be considered a two filling procedure.
 2. Crowns, of the following materials and only in those cases where the breakdown of tooth structure is excessive:
 - (a) Stainless steel, deciduous or permanent, anterior or posterior teeth
 - (b) Preformed plastic, anterior teeth only, deciduous or permanent
 - (c) Acrylic or porcelain veneer, permanent anterior teeth only

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184E.I.d. - 184E.I.f.4.

- d. Endodontics with the following limitations:
 - 1. Root canal therapy and/or apicoectomy shall be covered as follows:
 - (a) For upper and lower six (6) anterior teeth and then only when the retention of the tooth in site is necessary to maintain the integrity of the dentition and the prognosis is favorable.
 - (b) For posterior teeth only in cases with a full dentition or when the tooth is the only source for an abutment tooth or the integrity of the bite would be seriously affected.
 - 2. Apexification (not including root canal treatment but includes all visits to complete the service).
- e. Prosthodontics with the following limitations:
 - 1. Prostheses will only be approved if the patient can tolerate and is expected to use them on a regular basis.
 - 2. Removable, complete and partial denture prostheses only
 - 3. Replacement of existing dentures, only once in any five (5) years from the date of service of the existing dentures. Exceptions will be considered where the absence of dentures would create an adverse condition jeopardizing the patient's medical health.
 - 4. Relining or rebasing the existing dentures not more than once in any two (2) year period.
 - 5. Denture labeling, for patients in long term care facilities only
- f. Dental Surgery with the following limitations:
 - 1. Suture of laceration of the mouth, in accident cases only and not cases incidental to and connected with dental surgery
 - 2. Gingivectomy, for severe side effects caused by medication
 - 3. Replant avulsed anterior tooth, not in conjunction with a root canal
 - 4. Bone grafts, mandible, restricted to the replacement of bone previously removed by radical surgery procedure.

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184E.I.g. - 184E.I.k.

- g. Exodontia (extractions)
- h. Orthodontics under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program with the following limitations:
 - 1. Orthodontic Screening, one (1) per provider for the same recipient
 - 2. Orthodontic consultation, one (1) per provider for the same recipient
 - 3. Preliminary Diagnostic assessment casts/study models, one (1) per provider for the same recipient
 - 4. Comprehensive Diagnostic Assessment, one (1) per provider for the same recipient
 - 5. Initial appliance, one (1) per provider for the same recipient
 - 6. Active treatment, up to a maximum of thirty (30) months per recipient
 - 7. Retainer appliances, may be replaced only once per dental arch for the same recipient regardless of the reason
 - 8. Orthodontic services are limited to recipients under twenty-one (21) years of age
 - 9. All orthodontic services must be provided by a qualified dentist as defined in Section 184.B.
- i. Outpatient hospital services by licensed dental personnel performing within the scope of their profession
- j. Alveolectomy (Alveoplasty), only when an edentulous ridge is involved (not in conjunction with extractions)
- k. Patient Management, a patient management fee may be claimed in connection with a dental service to individuals who, because of cognitive disabilities, are limited in their ability to understand directions and thus require additional time on the part of the dentist to deliver services.

In order to access the patient management fee, the dental provider must satisfy two documentation requirements:

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1. The provider must document the specific diagnosis in the patient's record. A diagnosis of moderate or severe or profound mental retardation will satisfy the diagnosis requirement.
2. The provider must have in the patient's record the signature of a physician or a professional staff member of the Department of Mental Retardation, attesting to the authenticity of the diagnosis.
 - I. General Surgical Anesthesia
 - m. Services covered are limited to those listed in the Department's Dental Fee Schedule
 - II. Dental Services Not Covered
 - a. Fixed bridges
 - b. Periodontia
 - c. Implants
 - d. Transplants
 - e. Cosmetic dentistry
 - f. Vestibuloplasty
 - g. Unilateral removable appliances
 - h. Partial dentures where there are at least eight (8) posterior teeth in occlusion, and no missing anterior teeth
 - i. Restorative procedures to deciduous teeth nearing exfoliation
 - j. Information provided the recipient by telephone
 - k. Office visits to obtain a prescription, the need for which has already been ascertained
 - l. The following surgical procedures are not covered unless orthodontia has been prior authorized: surgical exposure of impacted or unerupted teeth for orthodontic reasons; osteoplasty (osteotomy) of maxilla and/or other facial bones for midface hypoplasia or retention (LeFort type operation), without bone graft.
 - m. Canceled office visits or for appointments not kept.

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184E.II.n. - 184F.I.2.

- n. Admitting services or any inpatient dental services performed by the admitting dentist if the admission was not approved by the Department or its designate as medically necessary in either a preadmission or retrospective review (CONNCUR).

F. Need for Service and Authorization Process

I. Need for Service

The Department will pay for any dental services which are deemed by the Department to be medically necessary and that

- a. the services are within the scope of the dentist's profession, and
- b. the services are made part of the recipient's medical record.
- c. Orthodontia

1. The need for orthodontic service shall be determined on the basis of the magnitude of the malocclusion. Accordingly, the qualified dentist must fully complete the "Preliminary Handicapping Malocclusion Assessment Record" in accordance with the instructions section of the form. The Department deems orthodontic services to be medically necessary when a correctly scored total of twenty-four (24) points or greater is calculated from the preliminary assessment. However, if the total score is less than twenty-four (24) points, the Department shall consider additional information of a substantial nature about the presence of severe deviations affecting the mouth and underlying structures. Other deviations shall be considered to be severe if, left untreated, they would cause irreversible damage to the teeth and underlying structures.

2. If the total score is less than twenty-four (24) points, the Department shall consider additional information of a substantial nature about the presence of severe mental, emotional, and/or behavior problems, disturbances or dysfunctions, as defined in the most current edition of the Diagnostic Statistical Manual of the American Psychiatric Association, and which may be caused by the recipient's daily functioning. The Department will only consider cases where a diagnostic evaluation has been performed by a licensed psychiatrist or a licensed psychologist who has accordingly limited his or her practice to child psychiatry or child psychology. The evaluation must clearly and substantially document how the dentofacial deformity is related to the child's mental, emotional, and/or behavior problems, that orthodontic treatment is necessary and, in this case, will significantly ameliorate the problems.

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184F.I.3. - 184F.II.g.

3. A recipient who becomes Medicaid eligible and is already receiving active orthodontic treatment must demonstrate that the need for service requirements specified in Subsection 184F.I.c.1. were met before orthodontic treatment commenced, meaning that prior to the onset of treatment the recipient would have met the need for services requirements.

II. Prior Authorization

The following treatment and/or services require prior authorization by the Department.

- a. Radiographs
 1. Intraoral, complete series
 2. Any film in addition to four (4) periapical films
 3. Any films in addition to bitewings and three (3) periapicals
- b. Crowns, other than stainless or preformed plastic
- c. Dentures
 1. Full or partial dentures
 2. Reline or rebase lower or upper denture (chairside and/or laboratory)
- d. Root canal therapy, excluding apicoectomies, post and core, and canal preparation procedures when performed in conjunction with a root canal
- e. Change in dentists during a course of treatment
- f. Impactions
- g. Elective impactions require special consideration and will require x-rays supporting the need for service.

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- h. Gingevectomy
- i. Reposition forming tooth bud to another socket
- j. Apexification
- k. Permanent fillings in excess of one (1) per year to the same surfaces by the same provider.
- l. Alveolectomy (Alveoplasty) and/or drainage of an extra-oral alveolar abscess
- m. Osteoplasty (osteotomy)
- n. Orthodontic services following the initial Orthodontic Consultation and Preliminary Assessment including the following: Comprehensive Diagnostic Assessment, Initial Appliance, and Active Treatment.
- o. Pit and fissure sealants on first permanent molars (Tooth #3, 14, 19 and 30), all ages other than 5-10 inclusive.
- p. Pit and fissure sealants on second permanent molars (Tooth #2, 15, 18 and 31) all ages other than 10-16 inclusive.
- q. Patient management
- r. Fluoride treatment for recipients 21 years of age and over
- s. All services listed in the fee schedule identified by a single asterisk.
- t. Admission to an acute care hospital. This authorization is not necessary under the CONNCUR program if the recipient is also on Medicare.

III. Authorization Procedure

- a. CONNCUR (Connecticut Case Program) Authorization

CONNCUR is a utilization and quality review program for Medicaid (Title XIX) designed by the Department of Social Services in compliance with the Code of Federal Regulations, 42 CFR 431.

CPRO will review hospital admissions for medical necessity provided in the appropriate setting.

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184F.III.a. - 184F.III.b.1.a.

For all cases meeting DSS coverage policies (except those also on Medicare) and appropriateness of the admission (using ISD and other criteria developed by CPRO) a unique eight digit authorization number will be issued beginning with "W" followed by seven numerics to be included on the hospital's bill. Confirmation of the number will be sent by CPRO to both the dentist and the hospital.

1. Authorization for admission to and subsequent dental services performed in an acute care general hospital by the admitting dentist needs authorization of the admission from the agency's designate, the Connecticut Peer Review Organization (CPRO; 1-800-628-7337).
2. Non-emergency admissions require review prior to hospital admission.
3. Emergency admissions require review within two business days of admission.

b. Prior Authorization

The procedure of course of treatment must be initiated within twelve (12) months of the date of authorization. The "EDS Dental Claim Form" is used to request prior authorization. Such authorization and requests for authorization must be approved prior to the onset of treatment. The form is submitted to:

Department of Social Services
Attn: Dental Consultant
25 Sigourney St.
Hartford, Connecticut 06106-5033

Prior authorizations are subject to the following conditions:

1. The initial authorization period is valid up to twelve (12) months from the date service is authorized, providing that the patient remains eligible for Medicaid.
 - a. When prior authorization is given for twelve (12) orthodontic active treatments it will be for a period of twenty-four (24) months.

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184F.III.b.2. - 184F.III.b.5.(a)

2. Treatment plan procedures which have been prior authorized but treatment was not begun prior to the lapse of the twelve (12) month limit (for twelve (12) active treatments of orthodonture the limit is twenty-four (24) months), must be reauthorized by submitting a new claim form for those procedures remaining from the original treatment plan, documenting the necessity for an extension. The request will be reviewed by the Dental Consultant. If no portion of the original treatment was completed, submit the original form for an authorization update.
3. Only authorization for emergency care will be granted by telephone during normal working hours. In emergency situations which occur after working hours or on non-working days, the dentist is to call the Dental Consultant in Central Office for verbal approval the following working day. When such authorization is given, a complete report of emergency care and the treatment must be submitted to the Department in every case within 48 hours using the Dental Claim Form and stating the name of the Dental Consultant giving verbal approval, and the date the approval is given.
4. A complete description must be included with a request for the following procedures:
 - (a) Denture repair
 - (b) All oral surgical procedures
 - (c) Emergency care
5. Orthodontics

Requests for authorization for orthodontic services must be submitted to the Department by a qualified dentist in the following sequence:

 - (a) To obtain the initial authorization the orthodontist first submits the authorization request for the Comprehensive Diagnostic Assessment, together with the Preliminary Assessment Form (W-1428), study models, and other supporting documentation.

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184F.III.b.5.(b) - 184F.III.b.5.(f)

- (b) The study models must clearly show the occlusal deviations and support the total point score of the preliminary assessment. For approved cases, to initiate the first period of twelve active treatments the orthodontist must submit the authorization request for the Initial Appliance and Active Treatment along with
 - (1) a written treatment plan detailing estimated length of active treatment and retention period
 - (2) the diagnosis
 - (3) a description of the appliance to be utilized
 - (4) a list of all other medical or dental treatment which is necessary in preparation for, or completion of, the orthodontic treatment.
- (c) For each additional period of active treatment and/or retention the qualified dentist must submit the authorization form with study models and/or photographs which clearly show the progress of treatment. No authorization shall be given if there is evidence that little or no progress has been made at the end of twelve treatments. In this case, the qualified dentist shall be required to resubmit the authorization request. The authorization shall be based on reasonable progress made in active treatment as deemed by the Department. There will be no monthly payment allowed during this period.
- (d) All requests for replacement of retainers must be accompanied by appropriate justification.
- (e) Any requests for modifications of the authorized treatment plan must include supporting documentation; however, no authorization shall be given beyond thirty (30) months of active treatment.
- (f) Address all requests for authorization for orthodontic services to:

Department of Social Services
Attn: Orthodontic Consultant
25 Sigourney St.
Hartford, Connecticut 06106-5033

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184F.III.b.6. - 184G.III.

6. X-rays

- (a) X-rays must be submitted with requests for impacted teeth, multiple extractions, crowns, root canals, reposition of tooth bud and other unusual instances in other procedures that require prior authorization.
- (b) Right and left bitewings are necessary for all root canal requests involving posterior teeth.
- (c) X-rays that have been taken for services requiring prior authorization must be attached to the EDS Dental Form. These X-rays will be returned to the provider of service if the provider's name and address appear on them.

G. Other

I. Modification of Treatment Plan

The Department reserves the right to alter, amend, or otherwise modify treatment plans, where such changes shall be in the best interest of the State, and when they do not deny proper service to the patient. Reconsideration of such decisions may be requested in writing to the Department providing evidence in support of such request. In disputed decisions, the matter will be referred to the appropriate Review Committee of the Connecticut State Dental Association, and the Department will be guided by the decision of the Review Committee.

II. X-Rays

Full mouth X-rays for which prior authorization has been granted must be presented, properly mounted, and readable. Unreadable films and those having no diagnostic value will be returned and new film requested at no cost to the Department. Such X-rays are to be made available on request to any other practitioner treating the same recipient, as authorized by the recipient.

III. Extractions

All necessary extractions must be recorded on one Treatment Plan, together with any other necessary procedures. The removal of hard and/or soft tissue and suturing following multiple extractions and surgical removals are considered sound surgical procedures and not an alveolectomy.

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184G.IV. - 184G.VII.d.

IV. Payment to Salaried Dentists

A dentist who is fully or partially salaried by a General Hospital, Public or Private Institution, Physicians' Group or Clinic may not receive payment from the Department unless that dentist maintains an office for private practice at separate location from the hospital, institution, physician group, or clinic in which the provider is employed. Dentists who are solely hospital, institution, physician group, or clinic based either on a full time or part time salary are not entitled to payment from the Department for services rendered to Title XIX recipients.

V. Subject to the above limitations, the dentist's service may be performed at:

- a. The dentist's private or group practice location, or
- b. Hospital or long-term care facility, or
- c. The recipient's home.

VI. Admission Exam/Annual Exam - PHC Section 19-13D8t

If the patient's physician deems it medically unnecessary, or the patient refuses to have all or any part of the dental examination performed, the exam need not be carried out.

VII. Orthodontics

- a. The recipient, together with the parent or guardian, should have the desire and the ability to complete an extended treatment plan as determined by the qualified dentist performing the treatment or other professionals involved with the recipient or family.
- b. When an orthodontic case is authorized by the Department, local Early Periodic Screening, Diagnostic and Treatment (EPSDT) staff will contact the recipient and the qualified dentist to help facilitate the recipient's participation in the completion of the treatment plan.
- c. The course of orthodontic treatment must be completed prior to the recipient's twenty-first (21st) birthday.
- d. The qualified dentist shall maintain a specific record for each recipient eligible for Medicaid reimbursement including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information and X-ray, a current treatment plan, pertinent treatment notes signed by the qualified dentist; and documentation of the dates of service. Records or documentation must be maintained for a minimum of five (5) years.

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184G.VII.d. - 184I.II.

For the retention period the qualified dentist shall submit, prior to initiating placement of retainers, study models and/or photographs clearly showing the case is ready for retention.

H. Billing Procedures

- I. All dental services performed on behalf of eligible patients and not requiring prior authorization must be recorded on the EDS Dental Claim Form and submitted to the Department's claims processing agent:

Electronic Data Systems Corporation (EDS)
Dental Claims
P.O. Box 2971
Hartford, CT 06104

II. Usual and Customary Charge

It is required that the amount billed to the Department represents the provider's usual and customary charge for the services delivered.

- III. The Dental Claim Form serves as a combined treatment plan record, a request for authorization, and a bill.

I. Payment

- I. Payments will be made at the lower of:

- a. The usual and customary charge to the public
- b. The fee as contained in the dental fee schedule published by the Department.
- c. The amount billed by the provider.

II. Payment Rate

The Commissioner of Social Services establishes the fee contained in the Dental Fee Schedule. The fees are based on moderate and reasonable rates prevailing in the respective communities where the service is rendered.

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184I.III. - 184I.III.g.6.

III. Payment Limitations

- a. When dental treatment is necessary, the examination and charting of the oral cavity (including filling out the EDS Dental Claim Form) will be included in the total cost of treatment.
- b. The fee for root canal treatment and/or apicoectomies includes all pre and post-operative X-rays, but not the final restoration.
- c. Fees listed in the dental fee schedule for oral surgery and exodontia include pre-operative and post-operative care.
- d. Fees for amalgam restoration include local anesthesia, base and polishing where necessary.
- e. Fees for exodontia include local anesthesia.
- f. Dental cleaning for children under 21 years of age is paid at the lower rate for this service as stipulated in the Dental Fee Schedule.
- g. Orthodontics
 - 1. An initial payment and monthly payments are made for active treatment and orthodontic services.
 - 2. The initial payment covers the placement of the initial appliances.
 - 3. No payment is made for monitoring growth and development.
 - 4. A dentist, other than a qualified dentist as defined in these regulations, may receive payment for an orthodontic screening. The screening includes oral examination and/or examination of the patient's records for the purposes of completing Sections I, II and IIIA-D of the Preliminary Handicapping Malocclusion Assessment Record Form, W-1428.
 - 5. The fee for the orthodontic consultation includes a dental screening and the completion of the preliminary assessment form. No separate payment shall be made to a qualified dentist for the orthodontic screening.
 - 6. The number of monthly payments is limited to the number of months of active treatment stipulated in the treatment plan as approved by the Department.

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184I.III.g.7. – 184I.III.h.

7. The monthly installment rate for active treatment is based on the average of one (1) visit per month and will be payable once a month during the authorized active treatment period no matter how many times the orthodontist sees the patient during this period.
 8. Payment for the comprehensive diagnostic assessment includes all diagnostic measures, e.g., X-rays, photographs or slides, and the written treatment plan. No separate payment is made for individual diagnostic materials except the preliminary assessment study models.
 9. For a recipient who becomes ineligible for Medicaid during the authorized term of active treatment, the final payment from the Department shall be made for the month in which the recipient becomes ineligible for Medicaid or EPSDT services, whichever comes first.
 10. The cost of the initial retainer appliance, including fitting, adjustments and all necessary visits, is included in the first twenty-four (24) monthly active treatment installments.
 11. The fee for the replacement of retainer appliances includes the fitting and all necessary visits.
- h. Payment may not be made or may be taken back from the admitting dentist retrospectively if it is determined by CPRO during a retrospective review that the admission was inappropriate.

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CLINICS
171. – 171A.III.

171 Clinics

For the purposes of this Section, clinics are facilities not associated with a hospital. They provide medical or medically-related services for diagnosis, treatment and care of persons with chronic or acute conditions.

This section is divided into four (4) subsections comprising the major fields of medical and medically-related provider groups associated with clinic-based services. The descriptions, citations, and definitions in sections 171A. and 171B. below, apply to all of the clinic types described herein.

A. Legal Bases

- I. Code of Federal Regulations: 42 CFR 440.2a, 440.90, 440.130
- II. Connecticut General Statutes: Section 17b-262
- III. Regulations of Connecticut State Agencies:
Sections 17-134d2(9), 17-134d-56

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MEDICAL SERVICES POLICY

CLINICS
171B. - 171B.V.

B. Definitions

I. Free Standing Clinic

“Free Standing Clinic” means a facility providing clinic and off-site medical services by or under the direction of a physician or dentist, in a facility that is not part of a hospital.

II. Medical or Medically-Related Services

“Medical or Medically-Related Services” means services which are required in the diagnosis, treatment, care, or prevention of some physical or emotional problem which affects the health of an individual.

III. Clinic Services

“Clinic Services” means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that

- a. Are provided to outpatients;
- b. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and
- c. Are furnished by or under the direction of a physician or dentist.
- d. Are performed at the clinic, a satellite site, school, or community center.

IV. Off-Site Medical Services

“Off-Site Medical Services” means diagnostic, preventive, and rehabilitative services furnished by or under the direction of a physician or dentist employed by or under contract to a free-standing clinic to a Medicaid eligible recipient at a location other than the locations listed elsewhere in this subsection. Such off-site locations are the recipient’s home, acute care hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded. Off-site services (as may be restricted by location in accordance with each clinic subsection herein) include: Mental Health Services, Occupational Therapy Services, Physical Therapy Services, Speech Therapy Services, Audiological Services, Physician’s Services, Respiratory Therapy Services, Primary Care Services, and Dental Services.

V. All-inclusive fee

“All-inclusive fee” means a fee which covers any and all services provided by the clinic for a particular visit or program. No additional payment will be made by the Department for services rendered during that visit.

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CLINICS
171B.VI. - 171B.X.

VI. Outpatient

“Outpatient” means a patient who is receiving professional services at an organized medical facility, or distinct part of such a facility, which is not providing him with room and board and professional services on a continuous 24 hour-a-day basis.

VII. Patient

“Patient” means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

VIII. By or Under the Directions of a Physician or Dentist

“By or under the direction of a physician or dentist” means a free-standing clinic’s services may be provided by the clinics’ allied health professionals (as defined in Sections 171.1 through 171.4) whether or not a physician is physically present at the time that medical services are provided. The physician

- a. must assume professional responsibility for the services provided;
- b. must assure that the services are medically appropriate, i.e., the services are intended to meet a medical need, as opposed to needs which are clearly only social, recreational or educational;
- c. need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

IX. Plan of Care

“Plan of Care” means a written individualized plan. Such plan shall contain the diagnosis, type, amount, frequency, and duration of services to be provided and the specific goals and objectives developed and based on an evaluation and diagnosis for the maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level.

X. Satellite Site

“Satellite Site” means a location separate from the primary clinic facility at which clinic services are furnished by clinic professionals on an ongoing basis meaning with stated hours per day and days per week.

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CLINICS
171B.XI.

XI. Home

“Home” means the recipient’s place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

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DENTAL CLINICS
171.3. - 171.3A.III.

171.3 Dental Clinics

A dental clinic provides diagnostic, preventive, or restorative procedures to outpatients in a clinic staffed by dentists, dental hygienists, dental assistants and other dental professionals performing within the scope of their profession in accordance with State law. Services performed relate to

- I. The teeth and other structures of the oral cavity; and
- II. Disease, Injury, or impairment of general health only as it relates to the oral health of the recipient.

(Refer to Section 171. for other applicable clinic services policy).

A. Legal Bases

- I. Code of Federal Regulations: 42 CFR 440.100, 440.130
- II. Connecticut General Statutes: Section 17b-262
- III. Regulations of Connecticut State Agencies:
Sections 17-134d2(9) and (10), 17-134d-35, 17-134d-56

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DENTAL CLINICS
171.3B. - 171.3C.III.a.

B. Definitions

I. Dentist:

“Dentist” means an individual licensed by the State Department of Health Services to practice dentistry or dental surgery.

II. Dental Clinic:

For the purpose of this section, “Dental Clinic” means a clinic not associated with a hospital which has been issued a permit from the Connecticut State Dental Commission to operate a clinic for the purpose of providing diagnostic, preventive, or corrective dental procedures to outpatients. Services are performed by or under the supervision and control of a licensed dentist who assumes the primary responsibility for any dental procedures performed, as limited by State law, by licensed dental hygienists, trained dental assistants or dental students. The dentist need not be on the premises, but must be readily available, meaning within fifteen (15) minutes.

III. Emergency Service

“Emergency Service” means a service provided to a recipient for the relief from pain or treatment of infection or injury.

IV. Treatment Plan

“Treatment Plan” means a detailed list of dental services which a patient requires to return to or maintain oral health as determined and recorded in the patient’s file by the dentist.

V. Dentures

“Dentures” means artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.

C. Provider Participation

I. The provider must meet all applicable state licensing and certification requirements.

II. The provider must meet all Departmental enrollment requirements.

III. The following are requirements for satellite sites operated by dental clinics:

a. All satellite sites operated by dental clinics must have received a permit from the Connecticut State Dental Commission to provide dental services at such locations and document to the Department the Commission’s approval of such sites;

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171.3C.III.b. - 171.3E.I.a.1.(d)

- b. All clinics must document to the Department the names and titles of satellite clinical staff and scheduled hours of operation (hours per day/days per week) and description of services provided at such sites;
- c. All such sites must otherwise comply with the provisions of this section of the Department's Medical Services Manual covering dental clinic services;
- d. In cases in which the clinic has a special arrangement to provide services in another organized facility, the clinic must submit to the Department a copy of a written agreement between the clinic and such facility stipulating the services to be provided at such facility;
- e. There must be adequate private office space in which to conduct direct patient care and treatment and administrative services.

D. Eligibility

Payment for clinic dental services is available for all persons eligible for Medicaid subject to the conditions and limitations which apply to these services.

E. Services Covered and Limitations

Except for the limitations and exclusions listed below, the Department will pay for clinic dental services which conform to accepted methods of diagnosis and treatment, but will not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the Department to treat the recipient's diagnosis, symptoms or medical history.

I. Dental Clinic Services Covered and Limitations

a. Diagnostic Services, including

1. Radiographs

- (a) Intraoral, complete series (full mouth) consisting of at least ten (10) periapical films plus bitewings, limited to once during any three (3) year period.
- (b) Bitewing films, only once during any six (6) month interval per provider.
- (c) Periapical films, but the single first film is not covered on the same date of service as bitewings, panoramic, or lateral jaw films.
- (d) Temporomandibular Joint

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171.3E.I.a.1.(e) - 171.3E.I.b.3.

- (e) Sialography
- (f) Panoramic or lateral jaw
- 2. Dental screenings, limited to
 - (a) the Early and Periodic Screening and Diagnosis Treatment Program (EPSDT) for children under 21 years of age
 - (b) once yearly (at twelve (12) month intervals) per provider
- 3. Oral examination, limited to patients in Intermediate Care and Skilled Nursing Facilities pursuant to Public Health Code Section 19-13D8t, as revised October 1981, and subject to the following:
 - (a) Admission Exam. For each patient, the Department will pay the same dental clinic for only one admission exam, regardless of the number of individual admissions. For example, if a patient moves from one facility to another and retains the dental clinic which performed the admission exam at the first facility, that clinic cannot get paid for another admission exam;
 - (b) Annual Exam, limited to one per year, meaning no sooner than one year from the date of the admission exam, and only one and annual exam per year will be paid for each patient;
 - (c) The examination is performed in the facility only.
- b. Preventive Services, subject to the following:
 - 1. Prophylaxis, once every six (6) months per provider.

Prophylaxis includes cleaning, supra and subgingival scaling, and polishing teeth. (Refer to Section I.III.f.)
 - 2. Fluoride treatment for children under 21 years of age will be paid for no more than once a year (at 12 month intervals) per provider. Fluoride treatment must be an application of Acidulate Phosphate Fluoride.
 - 3. Space maintainers

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DENTAL CLINICS
171.3E.I.b.4. - 171.3E.I.d.2.

4. Night Guard
- c. Restorative services, limited to the restoration of carious, permanent, and primary teeth, with
 1. Fillings
 - (a) Permanent fillings using silver amalgam or composite resin material are limited to one (1) per year to the same surface by the same provider unless authorized by the dental consultant.
 - (b) Temporary sedative fillings, only when done to treat dental pain requiring emergency treatment.
 - (c) More than one amalgam filling on a single surface will be considered a single filling. Anterior, synthetic or composite fillings involving more than one surface will be considered as a single filling. Only those fillings involving the incisal corner will be considered a two filling procedure.
 2. Crowns, of the following materials and only in those cases where the breakdown of tooth structure is excessive:
 - (a) Stainless steel, deciduous or permanent, anterior or posterior teeth
 - (b) Preformed plastic, anterior teeth only, deciduous or permanent
 - (c) Acrylic or porcelain veneer, permanent anterior teeth only
- d. Endodontics with the following limitation:
 1. Root canal therapy and/or apicoectomy shall be covered as follows:
 - (a) For upper and lower six (6) anterior teeth only when the retention of the tooth in site is necessary to maintain the integrity of the dentition and the prognosis is favorable.
 - (b) For posterior teeth only in cases with a full dentition or when the tooth is the only source for an abutment tooth or the integrity of the bite would be seriously affected.
 2. Apexification

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DENTAL CLINICS
171.3E.I.e. - 171.3E.I.j.

- e. Prosthodontics with the following limitations:
 - 1. Prostheses will only be approved if the patient can tolerate and is expected to use them on a regular basis.
 - 2. Removable, complete and partial denture prostheses only
 - 3. Replacement of existing dentures, only once in an five (5) years from the date of service of the existing dentures. Exceptions will be considered where the absence of dentures would create an adverse condition jeopardizing the patient's medical health.
 - 4. Relining or rebasing existing dentures not more than once in any two (2) year period.
 - 5. Denture labeling, for patients in long term care facilities only.

- f. Oral Surgery with the following limitations:
 - 1. Antibiotic injections in connection with oral surgery, only in those special cases requiring a rapid buildup of blood levels.
 - 2. Suture of laceration of the mouth, in accident cases only and not cases incidental to and connected with dental surgery.
 - 3. Gingivectomy, for severe side effects caused by medication
 - 4. Replant avulsed anterior tooth, not in conjunction with a root canal
 - 5. Bone grafts, mandible, restricted to the replacement of bone previously removed by radical surgery procedure.

- g. Exodontia (extractions)

- h. Orthodontia

- i. Alveolectomy (Alveoplasty), only when an edentulous ridge is involved (not in conjunction with extractions)

- j. Services covered are limited to those listed in the Department's Dental Fee Schedule.

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171.3E.II. - 171.3F.I.c.

II. Clinical Services Not Covered

- a. Fixed bridges
- b. Periodontia
- c. Implants
- d. Transplants
- e. Cosmetic dentistry
- f. Vestibuloplasty
- g. Unilateral removable appliances
- h. Partial dentures where there are at least eight (8) posterior teeth in occlusion, and no missing anterior teeth
- i. Restorative procedures to deciduous teeth nearing exfoliation
- j. Oral examinations to persons age 21 or older
- k. Information provided the recipient by telephone
- l. Clinic or off-site visits to obtain a prescription, the need for which has already been ascertained
- m. Canceled office visits or for appointments not kept.
- n. Oral examination or survey of patients in nursing facilities, or recipients over twenty (20) years of age, except as limited under Section E of this policy.

F. Need for Service and Authorization Process

I. Need for Service

The Department will pay for any dental clinic or off-site services which are deemed by the Department to be medically necessary and that

- a. the services furnished by the clinic are within the scope of the dental profession under State law; and
- b. the services are made part of the recipient's dental record;
- c. The services are recommended by a dentist.

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DENTAL CLINICS
171.3F.II. - 171.3F.II.m.

II. Prior Authorization

The following treatment and/or services require prior authorization by the Department.

- a. Radiographs
 - 1. Intraoral, complete series
 - 2. Any film in addition to four (4) periapical films
 - 3. Any films in addition to bitewings and three (3) periapicals
- b. Crowns, other than stainless or preformed plastic
- c. Dentures
 - 1. Full or partial dentures
 - 2. Duplicate upper or lower complete denture
 - 3. Reline or rebase lower or upper denture (chairside and/or laboratory)
- d. Root canal therapy, including apicoectomy performed in conjunction with root canal
- e. Space maintainers
- f. Any combination of more than three (3) surgical procedures, for example, more than three (3) extractions
- g. Change in dentists during a course of treatment
- h. Impactions
- i. Elective impactions require special consideration and will require X-rays supporting the need for service
- j. Gingivectomy
- k. Night Guard
- l. Reposition forming tooth bud to another socket
- m. Apexification

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171.3F.II.n. - 171.3F.III.c.

- n. Permanent fillings in excess of one (1) per year to the same surfaces by the same provider
- o. All dental services for recipients residing in medical facilities needing transportation by chaircar or ambulance (See below, III.g.)
- p. All cases for which the dentist is requesting hospital operating room services on an inpatient or same day surgery basis. Documentation of medical necessity is required.

III. Authorization Procedure

The procedure of course of treatment must be initiated within six (6) months of the date of authorization.

The “EDS Dental Claim Form” is used to request prior authorization. Such authorizations and requests for authorization must be approved prior to the onset of treatment. The form is submitted to:

Department of Social Services
Attn: Dental Consultant
25 Sigourney St.
Hartford, Connecticut 06106-5033

Prior authorizations are subject to the following conditions:

- a. The initial authorization period is valid up to six (6) months from the date service is authorized, providing that the patient remains eligible for Medicaid.
- b. Treatment plan procedures which have been prior authorized but treatment was not begun prior to the lapse of the six (6) month limit, must be reauthorized by submitting a new claim form for those procedures remaining from the original treatment plan, documenting the necessity for an extension. The request will be reviewed by the Dental Consultant.
- c. Only authorization for emergency care will be granted by telephone during normal working hours. In emergency situations which occur after working hours or on non-working days, the dentist is to call the Dental Consultant in Central Office for verbal approval the following working day. When such authorization is given, a complete report of emergency care and the treatment must be submitted to the Department in every case within 48 hours using the Dental Claim Form and stating the name of the Dental Consultant giving verbal approval, and the date the approval is given.

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171.3F.III.d. - 171.3G.I.

- d. A complete description must be included with a request for the following procedures:
 - 1. Denture repair
 - 2. All oral surgical procedures
 - 3. Emergency care
- e. Request for orthodontic treatment due to a cleft palate must have a report from a licensed orthodontist which includes a diagnosis, prognosis, and estimated fee for adequate minimum correction. The orthodontist submits his report to the Department on the EDS Dental Form.
- f. X-rays
 - 1. X-rays must be submitted with requests for impacted teeth, multiple extractions, crowns, root canals, reposition of tooth bud and other unusual instances in other procedures that require prior authorization.
 - 2. Right and left bitewings are necessary for all root canal requests involving posterior teeth.
 - 3. X-rays that have been taken for services requiring prior authorization must be attached to the EDS Dental Form. These X-rays will be returned to the provider of service if the provider's name and address appear on them.
- g. Transportation requests to obtain dental services must be indicated in the remarks section of the dental form.

G. Other

I. Modification of Treatment Plan

The Department reserves the right to alter, amend, or otherwise modify treatment plans, where such changes shall be in the best interest of the State, and when they do not deny proper service to the patient. Reconsideration of such decisions may be requested in writing to the Department providing evidence in support of such request. In disputed decisions, the matter will be referred to the appropriate Review Committee of the Connecticut State Dental Association, and the Department will be guided by the decision of the Review Committee.

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DENTAL CLINICS
171.3G.II. - 171.3G.V.a.6.

II. X-Rays

Full mouth X-rays for which prior authorization has been granted must be presented, properly mounted, and readable. Unreadable films and those having no diagnostic value will be returned and new film requested at no cost to the Department. Such X-rays are to be made available on request to any other practitioner treating the same recipient, as authorized by the recipient.

III. Extractions

All necessary extractions must be recorded on one Treatment Plan, together with any other necessary procedures. The removal of hard and/or soft tissue and suturing following multiple extractions and surgical removals are considered sound surgical procedures and not an alveolectomy.

IV. Dentists who are fully or partially salaried by a clinic will not receive payment from the Department unless the dentist maintains an office for private practice at separate location from the clinic.

Dentists who are solely clinic-based either on full time or part time salary are not entitled to payment from the Department for services rendered to Title XIX recipients. Services are billed by the provider clinic.

Dentists who maintain an office for private practice separate from the clinic may bill for services provided at the private location or for services provided to the dentist's private practice patients at the clinic only if the patient is not a clinic patient.

V. Documentation Requirements

a. A record of each service performed must be on file in the recipient's individual dental record.

1. the specific services rendered;
2. the date the services were rendered;
3. for therapy services, the amount of time it took to complete the session on that date;
4. the name and title of the person performing the services on that date;
5. the location at which the services were rendered;
6. the recipient's individual dental record must contain a progress note for each encounter.

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171.3G.V.b. - 171.3I.II.b.

- b. All documentation must be entered in ink and incorporated into the patient's permanent dental record in a complete, prompt, and accurate manner. All documentation shall be made available to authorized Department personnel upon request as permitted by Federal law.
- c. In the case of off-site services, all individual dental records must be on file at the clinic.

H. Billing Procedures

- I. All dental services performed on behalf of eligible patients and not requiring prior authorization must be recorded on the EDS Dental Claim Form and submitted to the Department's claims processing agent:

Electronic Data Systems Corporation (EDS)
Dental Claims
P.O. Box 2971
Hartford, Connecticut 06104

- II. The Dental Claim Form serves as a request for authorization and a bill.

I. Payment

- I. Payment will be made at the lower of:
 - a. The usual and customary charge to the public
 - b. The fee as contained in the dental fee schedule published by the Department.
 - c. The amount billed by the provider.
- II. Payment Rate
 - a. The Commissioner of Social Services establishes the fee contained in the Dental Fee Schedule. The fees are based on moderate and reasonable rates prevailing in the respective communities where the service is rendered.
 - b. Subject to the service limitations stated in this policy, dental clinics shall be reimbursed by the Department for services covered in accordance with the Department's fee schedule covering dental clinic services regardless of the site where the service is provided.

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DENTAL CLINICS
171.3I.III. - 171.3I.III.f.

III. Payment Limitations

- a. When dental treatment is necessary, the examination and charting of the oral cavity (including filling out the EDS Dental Claim Form) is included in the total cost of treatment.
- b. The fee for root canal treatment and/or apicoectomies includes all pre- and post-operative X-rays, but not the final restoration.
- c. Fees listed in the dental fee schedule for oral surgery and exodontia include pre-operative and post-operative care.
- d. Fees for amalgam restoration include local anesthesia, base and polishing where necessary.
- e. Fees for exodontia include anesthesia.
- f. Dental cleaning for children under 21 years of age is paid at the lower rate for this service as stipulated in the Dental Fee Schedule.

REGULATIONS OF CONNECTICUT STATE AGENCIES
DEPARTMENT OF SOCIAL SERVICES
Concerning
Requirements for Payment of Public Health Dental Hygienist Services

Section 17b-262-693

Scope

Sections 17b-262-693 to 17b-262-700, inclusive, set forth the requirements for payment of public health dental hygienist services for persons determined eligible for Connecticut's Medicaid Program pursuant to Section 17b-262 of the Connecticut General Statutes.

Section 17b-262-694

Definitions

As used in sections 17b-262-693 to 17b-262-700, inclusive, the following definitions shall apply:

- (1) "Client" means a person eligible for services under the department's Medicaid program;
- (2) "Clinic" means an "outpatient clinic" as defined in section 19-13-D45 of the Regulations of Connecticut State Agencies;
- (3) "Commissioner" means the Commissioner of Social Services or his or her agent;
- (4) "Community health center" means a "community health center" as defined in section 19a-490a of the Connecticut General Statutes;
- (5) "Dental examination" means inspecting and charting of the oral structures;
- (6) "Dental hygienist" means a dental hygienist licensed to practice dental hygiene pursuant to sections 20-126h to 20-126x, inclusive, of the Connecticut General Statutes;
- (7) "Dental hygienist services" means "the practice of dental hygiene" as defined in section 20-126l(a)(3) of the Connecticut General Statutes;
- (8) "Dentist" means a dentist licensed to practice dentistry pursuant to section 20-108 of the Connecticut General Statutes or who is licensed to practice dentistry in another state;
- (9) "Department" means the Department of Social Services or its agent;
- (10) "Group home" means a "community residential facility" as defined in section 17a-220 of the Connecticut General Statutes or a "community residence" as defined in section 19a-507a of the Connecticut General Statutes;

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- (11) "Hospital" means a "general hospital" or "special hospital" as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;
- (12) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101 as amended from time to time;
- (13) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;
- (14) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and, is the least costly of multiple, equally effective alternative treatments or diagnostic modalities;
- (15) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;
- (16) "Medical record" means a medical record as set forth in section 19a-14-40 of the Regulations of Connecticut State Agencies;
- (17) "Nursing facility" means an institution as defined in 42 USC 1396(r)(a), as amended from time to time;
- (18) "Provider" means a "public health dental hygienist" as defined in subsection (19) of this section;
- (19) "Public health dental hygienist" means a dental hygienist who is providing services in accordance with section 20-1261(b)(1)(B) of the Connecticut General Statutes;
- (20) "School" means any preschool, elementary or secondary school or any college, vocational, professional or graduate school; and
- (21) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, "usual and customary" means the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

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Requirements for Payment of Public Health Dental Hygienist Services

Section 17b-262-695

Provider Participation

- (a) In order to participate in Medicaid and receive payment from the department, all providers shall meet and maintain all departmental enrollment requirements as set forth in sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.
- (b) All dental hygienists who participate in Medicaid shall be public health dental hygienists.

Section 17b-262-696

Eligibility

Payment for public health dental hygienist services shall be available on behalf of all persons eligible for Medicaid subject to the conditions and limitations that apply to these services.

Section 17b-262-697

Services Covered and Limitations

(a) Services Covered

- (1) The department shall pay for medically necessary and medically appropriate public health dental hygienist services provided to clients subject to the limitations listed in subsection (b) of this section.
- (2) The department shall pay providers only for those procedures listed in the provider's fee schedule.

(b) limitations

- (1) Dental examination is limited to one (1) every six (6) calendar months per client.
- (2) The department shall not pay for fluoride treatment except for the following clients, and shall limit treatment to one (1) time every six (6) calendar months per client:
 - (A) clients under age twenty one (21); and
 - (B) clients over age twenty one (21):
 - (i) using radiology services as oncology treatment on a regular basis; or

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- (ii) residing in nursing facilities or intermediate care facilities for the mentally retarded who have six (6) or more natural teeth.

- (3) Pit and fissure sealant is limited to:
 - (A) clients between the ages of five (5) through sixteen (16), inclusive;
 - (B) first and second permanent molars that are decay and restoration free; and
 - (C) one every five (5) calendar years per tooth.

- (4) A public health dental hygienist who is salaried at a practice location shall not bill the department for dental hygienist services for clients seen at this location.

- (5) Payment for dental hygienist services is available to all clients who have a need for these services, subject to the limitations in this subsection, when provided at the following locations only:
 - (A) a nursing facility;
 - (B) an ICF/MR;
 - (C) a group home;
 - (D) a school that does not have a dental clinic on site;
 - (E) a clinic or community health center that does not have a dental clinic on site;
or
 - (F) a hospital outpatient department that does not have a dental clinic on site.

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Requirements for Payment of Public Health Dental Hygienist Services

Section 17b-262-698

Services Not Covered

The department shall not pay for:

- (1) anything not explicitly allowed pursuant to section 17b-262-697 of the Regulations of Connecticut State Agencies;
- (2) information provided to the client over the telephone;
- (3) cancelled visits or services not provided;
- (4) any services provided by a public health dental hygienist free of charge to non-Medicaid clients;
- (5) anything of an unproven, experimental or research nature, or for services in excess of those deemed medically necessary or medically appropriate by the department to treat a client's condition, or for services not directly related to the client's diagnosis, symptoms, or medical history; or
- (6) any services provided by a public health dental hygienist in a dental office, a dental clinic or a location other than those set forth in section 17b-262-697(b)(5) of the Regulations of Connecticut State Agencies.

Section 17b-262-699

Payment Rate and Billing Procedure

- (a) The provider may sign claims and bill directly and shall submit claims to the department in accordance with the procedures set forth in section 17b-262-529 of the Regulations of Connecticut State Agencies and the billing instructions specific to a public health dental hygienist.
- (b) The commissioner shall establish the fees for dental hygienist services performed by the public health dental hygienist pursuant to section 4-67c of the Connecticut General Statutes;
- (c) The provider shall bill the usual and customary charge and the department shall pay the lowest of:
 - (1) the usual and customary charge;

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- (2) the amount billed by the provider to the department; or
- (3) the amount in the applicable fee schedule as published by the department.

Section 17b-262-700

Documentation

- (a) The provider shall maintain a client file that shall include, but not be limited to, the following information:
 - (1) identifying data:
 - (A) name of client;
 - (B) address;
 - (C) date of birth;
 - (D) gender; and
 - (E) Medicaid identification number;
 - (2) name, address, telephone number and license number of the public health dental hygienist responsible for the dental care;
 - (3) pertinent past and current health history of the client; and
 - (4) the medical record for the client.
- (b) All notes and reports in the client's medical record shall be type written or legibly written in ink or maintained electronically, dated and signed by the recording person with his or her full first name or first initial, surname and title. Electronic signatures shall be permissible in accordance with state and federal law.
- (c) Each public health dental hygienist shall document action taken to:
 - (1) refer for treatment any client with needs outside the public health dental hygienist's scope of practice;

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- (2) coordinate such referral for treatment to dentists; and
 - (3) provide meaningful medical and dental information to dentists to whom clients are referred.
- (d) For fluoride treatments provided to a client pursuant to section 17b-262-697(b)(2)(B)(i) of the Regulations of Connecticut State Agencies, the provider shall maintain documentation substantiating that the client is using radiology services as oncology treatment on a regular basis.
- (e) All required documentation shall be maintained for at least five (5) years or longer as required by state or federal law in the provider's file and shall be subject to review by the authorized department personnel. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, for five (5) years, or the length of time required by state or federal law, whichever is greatest.
- (f) Failure to maintain and provide all required documentation to the department upon request may result in the disallowance and recovery by the department of any future or past payments made to the provider.

